COPY

-Application

CAMM dba Patriot Homecare

CN1506-023

BONE MCALLESTER NORTON PLLC

June 9, 2015

Via Hand Delivery

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: Application for Certificate of Need- CAMM Care LLC dba Patriot Homecare (the "Application")

Gentlemen and Ladies:

Please find the enclosed Application consisting of one original and two copies for filing with the Tennessee Health Services and Development Agency. I have also enclosed our firm's check in the amount of $3,000.00 in payment of the filing fee. Please date stamp the enclosed copy of this letter and return to our courier.

If you have any questions, please contact me at (615) 238-6360.

Sincerely,

Anne Sumpter Arney

Anne Sumpter Arney

Enclosures

{01245203.1 }

Nashville City Center, Suite 1600 - 511 Union Street - Nashville, Tennessee 37219
615.238.6300 (Phone) - 615.238.6301 (Fax)

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building 500 Deaderick Street, 9th floor
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

INSTRUCTIONS FOR FILING AN APPLICATION FOR A CERTIFICATE OF NEED

Please read the following instructions, the Rules and Regulations of the Agency, and Tennessee Code Annotated, §68-11-1601 *et seq.*, prior to preparation of this application.

DOCUMENTATION: In preparing this application, it is the applicant's responsibility to demonstrate through its answers that the project is necessary to provide needed health care in the area to be served, that it can be economically accomplished and maintained, and that it will contribute to the orderly development of adequate and effective health care facilities and/or services in this area. Consult Tennessee Code Annotated, §68-11-1601 *et seq.*, Health Services and Development Agency Rule 0720-4-.01, and the criteria and standards for certificate of need document Tennessee's Health: Guidelines for Growth, for the criteria for consideration for approval. Tennessee's Health: Guidelines for Growth is available from the Tennessee Health Services and Development Agency or from the Agency's website at www.tennessee.gov/HSDA. Picture of the Present is a document, which provides demographic, vital, and other statistics by county available from the Tennessee Department of Health, Bureau of Policy, Planning, and Assessment, Division of Health Statistics and can be accessed from the Department's website at www2.state.tn.us/health/statistics/HealthData/pubs_title.htm.

Please note that all applications must be submitted in triplicate (1 original and 2 copies) on single-sided, unbound letter size (8 x 11 ½) paper, and not be stapled nor have holes punched. Cover letter should also be in triplicate. If not in compliance as requested, application may be returned or reviewing process delayed until corrected pages are submitted.

REVIEW CYCLES: A review cycle is no more than sixty (60) days. The review cycle begins on the first day of each month.

COMMUNICATIONS: All documents for filing an application for Certificate of Need with the Health Services and Development Agency must be received during normal business hours (8:00a.m. - 4:30p.m. Central Time) at the Agency office, located at the Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243. For the purpose of filing Letters of Intent, application forms, and responses to supplemental information, the filing date is the actual date of receipt in the Agency office. These documents, as well as other required documents must be received as original, signed documents in the Agency office. Fax and e-mail transmissions **will not** be considered to be properly filed documentation. In the event that the last appropriate filing date falls on a Saturday, Sunday, or legal holiday, such filing should occur on the preceding business day. All documents are to be filed with the Agency in ***single-sided and in triplicate***.

LETTER OF INTENT: Applications shall be commenced by the filing of a Letter of Intent. The Letter of Intent must be filed with the Agency between the first day and the tenth day of the month prior to the beginning of the review cycle in which the application is to be considered. This allowable filing period is inclusive of both the first day and the tenth day of the month involved. The Letter of Intent must be filed in the form and format as set forth in the application packet.

Any Letter of Intent that fails to include all information requested in the Letter of Intent form, or is not timely filed, will be deemed void, and the applicant will be notified in writing. The Letter of Intent may be refiled but, if refiled, is subject to the same requirements as set out above.

PUBLICATION OF INTENT: Simultaneously with the filing of the Letter of Intent, the Publication of Intent should be published for one day in a newspaper of general circulation in the proposed service area of the project. The Publication of Intent must be in the form and format as set forth in the application packet. The Publication of Intent should be placed in the Legal Section in a space no smaller than four (4) column inches. Publication must occur between the first day and the tenth day of the month, inclusive.

1. A "newspaper of general circulation" means a publication regularly issued at least as frequently as once a week, having a second-class mailing privilege, includes a Legal Notice Section, being not fewer than four (4) pages, published continuously during the immediately preceding one-year period, which is published for the dissemination of news of general interest, and is circulated generally in the county in which it is published and in which notice is given.
2. In any county where a "newspaper of general circulation" does not exist, the Agency's Executive Director is authorized to determine the appropriate publication to receive any required Letter of Intent. A newspaper which is engaged in the distribution of news of interest to a particular interest group or other limited group of citizens, is not a "newspaper of general circulation."
3. In the case of an application for or by a home care organization, the Letter of Intent must be published in each county in which the agency will be licensed or in a regional newspaper which qualifies as a newspaper of general circulation in each county. In those cases where the Publication of Intent is published in more than one newspaper, the earliest date of publication shall be the date of publication for the purpose of determining simultaneous review deadlines and filing the application.

PROOF OF PUBLICATION: Documentation of publication must be filed with the application form. Please submit proof of publication with the application by attaching either the full page of the newspaper in which the notice appeared, with the ***mast and dateline intact***, or a publication affidavit from the newspaper.

SIMULTANEOUS REVIEW: Those persons desiring a simultaneous review for a Certificate of Need for which a Letter of Intent has been filed should file a Letter of Intent with the Agency and the original applicant (as well as any other applicant filing a simultaneous review), and should publish the Letter of Intent simultaneously in a newspaper of general circulation in the same county as the original applicant. The publication of the Letter of Intent by the applicant seeking simultaneous review must be published within ten (10) days after publication by the original applicant.

1. Only those applications filed in accordance with the rules of the Health Services and Development Agency, and upon consideration of the following factors as compared with the proposed project of the original applicant, may be regarded as applications filing for simultaneous review.

    (A) Similarity of primary service area;
    (B) Similarity of location;
    (C) Similarity of facilities; and
    (D) Similarity of service to be provided.

2. The Executive Director or his/her designee will determine whether applications are to be reviewed simultaneously, pursuant to Agency Rule 0720-3-.03(3).

3. If two (2) or more applications are requesting simultaneous review in accordance with the statute and rules and regulations of the Agency, and one or more of those applications is not deemed complete to enter the review cycle requested, the other applications(s) that is/are deemed complete shall enter the review cycle. The application(s) that is/are not deemed complete to enter the review cycle will not be considered as competing with the applications(s) deemed complete and entering the review cycle.

FILING THE APPLICATION: *All applications*, including applications requesting simultaneous review, must be filed in ***triplicate*** (original and two (2) copies) with the Agency within five (5) days after publication of the Letter of Intent. ***The date of filing is the actual date of receipt at the Agency office.***

Applications should have all pages numbered.

All attachments should be attached to the back of the application, be identified by the applicable item number of the application, and placed in alpha-numeric order consistent with the application form. For example, an Option to Lease a building should be identified as Attachment A.6., and placed before Financial Statements which should be identified as Attachment C. Economic Feasibility.10. The last page of an application should be the completed affidavit.

Failure by the applicant to file an application within five (5) days after publication of the Letter of Intent shall render the Letter of Intent, and hence the application, ***void***.

FILING FEE: The amount of the initial filing fee shall be an amount equal to $2.25 per $1,000 of the estimated project cost involved, but in no case shall the fee be less than $3,000 or more than $45,000. Checks should be made payable to the Health Services and Development Agency.

FILING FEES ARE NON-REFUNDABLE and must be received by the Agency before review of the application will begin.

REVIEW OF APPLICATIONS FOR COMPLETENESS: When the application is received at the Agency office, it will be reviewed for completeness. The application must be consistent with the information given in the Letter of Intent in terms of both project scope and project cost. ***Review for completeness will not begin prior to the receipt of the filing fee.***

1. If the application is deemed complete, the Agency will acknowledge receipt and notify the applicant as to when the review cycle will begin. "Deeming complete" means that all questions in the application have been answered and all appropriate documentation has been submitted in such a manner that the Health Services and Development Agency can understand the intent and supporting factors of the application. Deeming complete shall not be construed as validating the sufficiency of the information provided for the purposes of addressing the criteria under the applicable statutes, the Rules of the Health Services and Development Agency, or the standards set forth in the State Health Plan/Guidelines for Growth.

2. If the application is incomplete, requests by Agency staff for supplemental information must be completed by the applicant within sixty (60) days of the written request. Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days which is allowed by the statute. If the requested information is submitted within sixty (60) days of the request, but not by the date specified in the staff's letter, the application is not void, but will enter the ***next*** review cycle. If an application is not deemed complete within sixty (60) days after the written

notification is given by the Agency staff that the application is deemed incomplete, the application shall be deemed void. If the applicant decides to re-submit the application, the applicant shall comply with all procedures as set out by this part and a new filing fee shall accompany the refiled application.

Each supplemental question and its corresponding response shall be typed and submitted on a separate sheet of 8 1/2" x 11" paper, be filed in ***triplicate,*** and include a signed affidavit. All requested supplemental information must be received by the Agency to allow staff sufficient time for review before the beginning of the review cycle in order to enter that review cycle.

3. Applications for a Certificate of Need, including competing applications, will not be considered unless filed with the Agency within such time as to assure such application is deemed complete.

All supplemental information shall be submitted simultaneously and only at the request of staff, with the only exception being letters of support and/or opposition.

The Agency will promptly forward a copy of each complete application to the Department of Health or the Department of Mental Health and Developmental Disabilities for review. The Department reviewing the application may contact the applicant to request additional information regarding the application. The applicant should respond to any reasonable request for additional information promptly.

AMENDMENTS OR CHANGES IN AN APPLICATION: An application for a Certificate of Need which has been deemed complete ***CANNOT*** be amended in a substantive way by the applicant during the review cycle. Clerical errors resulting in no substantive change may be corrected.

* **WITHDRAWAL OF APPLICATIONS**: The applicant may withdraw an application at any time by providing written notification to the Agency.
* **TIMETABLE FOR CERTIFICATE OF NEED EXPIRATION**: The Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; *however*, the Agency may extend a Certificate of Need for a reasonable period upon application and good cause shown, accompanied by a non-refundable filing fee, as prescribed by Rules. An extension cannot be issued to any applicant unless substantial progress has been demonstrated. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.
* **For further information concerning the Certificate of Need process, please call the offices of the Health Services and Development Agency at 615/741-2364.**
* **For information concerning the Joint Annual Reports of Hospitals, Nursing Homes, Home Care Organizations, or Ambulatory Surgical Treatment Centers, call the Tennessee Department of Health, Office of Health Statistics and Research at 615/741-1954**
* **For information concerning Guidelines for Growth call the Health Services and Development Agency at 615/741-2364. For information concerning Picture of the Present call the Department of Health, Office of Health Statistics at 615/741-9395.**
* **For information concerning mental health and developmental disabilities applications call the Tennessee Department of Mental Health and Developmental Disabilities, Office of Policy and Planning at 615/532-6500.**

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A"*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

1. ***Name of Facility, Agency, or Institution***

CAMM Care LLC
Name

514 Devonia Street — Roane
Street or Route — County

Harriman — TN — 37748-2115
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Anne Sumpter Arney — Attorney
Name — Title

Bone McAllester Norton PLLC — asarney@bonelaw.com
Company Name — Email address

511 Union Street, Suite 1600 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Counsel — 615-238-6360 — 615-687-2764
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

CAMM Care, LLC
Name — Phone Number

514 Devonia Street — Roane
Street or Route — County

Harriman — TN — 37748-2115
City — State — Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____
E. Corporation (Not-for-Profit) _____
F. Government (State of TN or Political Subdivision) _____
G. Joint Venture _____
H. Limited Liability Company X
Caleb Mullins own 100%
I. Other (Specify)_____ _____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity*** ***(If Applicable)***

N/A
Name

Street or Route — County

City — State — Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution*** ***(Check One)***

A.	Ownership	____	D.	Option to Lease	____
B.	Option to Purchase	____	E.	Other (Specify) ____	
C.	Lease of years (month to month)	__x__			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)____	____	I.	Nursing Home	____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	____	J.	Outpatient Diagnostic Center	____
C.	ASTC, Single Specialty	____	K.	Recuperation Center	____
D.	Home Health Agency	__x__	L.	Rehabilitation Facility	____
E.	Hospice	____	M.	Residential Hospice	____
F.	Mental Health Hospital	____	N.	Non-Residential Methadone Facility	____
G.	Mental Health Residential Treatment Facility	____	O.	Birthing Center	____
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	____	P.	Other Outpatient Facility (Specify)____	____
			Q.	Other (Specify) ____	____

8. **Purpose of Review** ***(Check) as appropriate--more than one response may apply)***

A.	New Institution	__x__	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility	____			
C.	Modification/Existing Facility	____			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)____	____	H.	Change of Location	____
			I.	Other (Specify)____	____
E.	Discontinuance of OB Services	____			
F.	Acquisition of Equipment	____			

9. **Bed Complement Data** N/A

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL					

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** N/A
Certification Type _____

11. **Medicaid Provider Number** N/A
Certification Type _____

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** No.

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** No. **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: **Executive Summary of Project**

Proposed Services

CAMM Care, LLC, dba, Patriot Homecare (the "Applicant" or "Patriot") seeks a Certificate of Need ("CON") to be licensed to provide home health services to beneficiaries of the United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program ("EEOICP"). The EEOICP was established by Congress to provide compensation and medical benefits to individuals who were employed by the Department of Energy ("DOE") and its predecessor agencies(and their contractors) who suffer from illnesses as a result of performing their job. Patriot is currently licensed by the Tennessee Department of Mental Health to provide personal support services and is an authorized provider of home health services under EEOICP. (A copy of Patriot's license and EEOICP provider enrollment is attached at Attachment B I.) Patriot seeks to establish a home health organization to provide EEOICP beneficiaries for skilled nursing services substantially similar to "private duty nursing" as defined in 42 CFR Section 440.80 including skilled nursing, homemaker and personal support services. The Applicant does not intend to provide the intermittent episodic care provided by most home health agencies rather the Applicant seeks to establish a home health agency dedicated to provide "private duty" type care to EEOICP beneficiaries.

The Applicant intends to continue to provide the personal support services it currently provides but also, to provide "private duty" type nursing services both through periodic visits and for 24/7 where required. These services allow the beneficiaries to live and have care provided in their own homes and to obtain these services from a single agency.

Equipment

No medical equipment will be purchased by the Applicant for use in the project.

Ownership

The Applicant is a Tennessee limited liability company which is wholly owned by Caleb Mullins, a resident of Roane County, Tennessee.

Service Area The Applicant seeks a CON to be licensed in Anderson, Knox, Meigs, Morgan and Roane counties (the "Service Area").

Need and Existing Resources

There is a need in the Service Area for a home health agency dedicated to providing "private duty" type care to EEOICP beneficiaries. Through the EEOICP, Congress recognized the need to provide care to former DOE employees, contractors and subcontractors who because of their governmental services were exposed to extremely toxic and hazardous substances. Many of these EEOICP beneficiaries now suffer from serious chronic and often terminal illness. EEOICP pays for the type of care its beneficiaries' need without any cost to the patient or any other state or federal program. The DOE has eight active worksites in Oak Ridge, Anderson County, Tennessee. Most, if not all, of the EEOICP beneficiaries who Patriot seeks to serve are former employees of these sites and live in the areas of Tennessee near Oak Ridge. As a result, the Applicant believes that in the counties surrounding these DOE worksites, there is a need to provide the scope of services that are a benefit of EEOICP which is greater than other areas of Tennessee and greater than the need calculated using the Guidelines for Growth. There is a need for the level of services that these individuals require and deserve. All of the counties in the Applicant's proposed Service Area are either the location of a DOE site or are contiguous counties adjacent to a county where a DOE worksite is located. However, based on the information in the 2014 Joint Annual Reports, the Applicant believes that there is only one other home health agency providing both homemaker and "private duty" type skilled nursing to EEOCIP beneficiaries in any of the counties within the Service Area and only three in the Service Area providing private duty services. According to statistics from the United States Department of Labor, as of May 25, 2015, there were 14,215 new EEOICP beneficiaries in Tennessee. In addition, all of the DOE worksites in Oak Ridge continue to operate. Therefore, it is likely that the number of individuals qualifying for EEOICP benefits will continue to grow and the need for home health services to these individuals will also continue to grow.

Project Costs, Funding and Financial Feasibility

The only cost associated with this project are $38,080 which is less that would be required to initiate home health services for an agency which was not already providing personal support services.. The project costs will be funded from the cash reserves of the Applicant. The project cost is reasonable and will not require any capital expenditures.

Staffing

In the first year of its operation, the Applicant will employ Megan Mullins as its administrator and a registered nurse to act as a director of nursing. In addition the Applicant intends to employ a marketing director, receptionist, and 30 personal care assistants, 10 FTE CNAs, 15 FTE LPNS and 2 FTE RNs. A copy of Ms. Mullins resume is attached at Attachment B-I.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. By identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service

will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response: The Applicant seeks to establish a home care organization to deliver home health services to eligible former employees of the Department of Energy, as well as their contractor and subcontractors, provided under the EEOICP. The EEOICP does not distinguish among the types of care provided in the home setting; therefore Patriot is currently licensed to provide personal support services by the state of Tennessee but is approved by the EEOICP to provide home health services. The Applicant currently serves a number of EEOICP beneficiaries with personal support services who have requested that Patriot also provide the skilled nursing services they need. These individuals would prefer to have all of their home care services provided by a single EEOICP provider. There are only three EEOICP home health agencies providing "private duty" type services in the proposed Service Area and only one of them also provides the type of personal support services that Patriot provides. EEOICP beneficiaries have only one choice if they want a single agency to provide both their homemaker services and "private duty" type nursing. This Application developed out of Patriot's desire to meet the needs of its current clients and to expand its services to provide the type of "private duty care" that it has observed many of the EEOICP beneficiaries require. The care available to an EEOICP beneficiary is different from the care paid for by other government and most private insurers. EEOICP pays for services, such as 24 hour-a-day care at home, and for personal care provided by a home health aide to provide assistance with bathing, dressing and using the bathroom. This type of service is needed by EEOICP beneficiaries who are generally very sick with progressive illness. Generally, this level of care is not possible in a patient's home because it is not a benefit covered by most insurance or government programs. However, this level of care is an EEOICP benefit. Patriot developed this proposal in order to establish an EEOICP provider to meet these special needs of the EEOICP beneficiaries.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: Not applicable.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF										

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. **Home Health Services x**
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response: The Applicant's need to provide home health services is based in the need it has observed in its current patients to receive personal care and nursing services from a single agency. Patriot is currently an authorized EEOICP home health provider providing personal support services to 15 EEOICP beneficiaries and seeks to establish a home health agency to expand its services to provide "private duty" type nursing services dedicated to its current patients as well as other EEOICP beneficiaries in the proposed Service Area. The Applicant is Tennessee Company owned by a Tennessee resident who seeks to provide the care needed by fellow Tennesseans in his community and the surrounding region who are EEOICP beneficiaries. The Applicant is already providing personal support care to some of these patients and proposes to expand its services to meet the level of nursing care they and other EEOICP beneficiaries' need. Typically, the individuals to whom the Applicant provides care are involved in progressive disease processes from which they do not recover and need level of nursing care that is not typically provided by home health agencies. The services provided by the Applicant will range from simple weekly visits to comprehensive, 24-hour, and seven day-a-week in-home care. These services will allow EEOICP beneficiaries to continue to live as independently as possible in the comfort of their own home.

D. Describe the need to change location or replace an existing facility.

Response: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):
   a. Describe the new equipment, including:
      1. Total cost (As defined by Agency Rule);
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.
   b. Provide current and proposed schedules of operations.
2. For mobile major medical equipment:
   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment;
   and e. List the owner for the equipment.
3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response: Not Applicable

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which**must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response: Site is a platted plot and has no acreage. See Attachment B-III A Plot Plan

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The site is located within the city limits of Harriman, Tennessee on a main street. There is no public transportation in Harriman.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response: See Attachment B-IV Drawing of Office Site.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
Response: NA

2. Proposed service area by County;

Response: Anderson, Knox, Meigs, Morgan and Roane.

3. A parent or primary service provider;

Response: Not Applicable

4. Existing branches; and

Response: Not Applicable

5. Proposed branches.
Response: Not Applicable

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

   b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

   Response: *Implementation of the State Health Plan.*

   (1). The purpose of the State Health Plan is to improve the health of Tennesseans. Tennessee's role in the atomic and nuclear industry has been and continues to be a source of pride for the Oak Ridge area, however, Tennesseans who work in this industry have since the 1940's are at risk for exposure to hazardous and toxic substances as a result their jobs. The Applicant seeks to provide "private duty" type services and personal support and homemaker services to those individuals who as a result of their work in Tennessee's atomic energy industry require more than involved and longer term care than the intermittent visits provided by traditional home health agency. The project will improve the health and quality of life of those Tennesseans who are EEOICP beneficiaries by assuring that their adequate and quality resources for their care. Letters of support from current clients of the Applicant are at Attachment C Need 1 (1).

   (2) Every citizen should have reasonable access to health care.
   The Project will increase the accessibility of healthcare in the Service Area by providing both nursing and homemaker services to EEOICP beneficiaries. Currently, in the Service Area, there is only one home health agency that is an EEOICP provider which provides "private duty" type care together with homemaker services.

   (3) The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.
   The Applicant is currently an EEOICP approved provider and a licensed provider of personal support services. The Applicant is already serving many EEOICP beneficiaries and the project would allow it to also provide "private duty" type nursing services to many of these same beneficiaries instead of their being required to either contract with the only other provider which provides the same combination of services or to receiver care from two separate providers which would be cumbersome and inefficient. In addition, the Applicant is a Tennessee small business with its business office located in a rural county. The Applicant is owned by a resident of Tennessee and a resident of the community that Patriot serves. Patriot's business is consistent with the need to provide economic opportunities to Tennessee owned small businesses.

(4) Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.
All of Applicant's employees and contractors will hold the appropriate license from the Tennessee Health Regulatory Boards. As a provider of personal support services, the Applicant maintains strict policies and procedures to monitor and ensure the quality of the care it provides. In its last licensing survey it received zero deficiencies. The Applicant will expand policies and procedures to include the new services provided by the project and the Administrator will be responsible for ensuring that this quality is maintained. In addition, if it is licensed as a home care organization it will be monitored by the Tennessee Department of Health Facilities.

(5) The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.
The Applicant is a Tennessee small business owned by a citizen of Tennessee which employs other Tennesseans and hopes to work with local colleges and vocational schools to assist with training nurses and CNA's. As a locally owned healthcare business, Patriot is committed to the health and economic welfare of the Service Area.

Guidelines for Growth.

1. The need for home health agencies/services shall be determined on a county by county basis.

   Response: The Applicant provides services specifically designed to meet the long term health care needs of individuals who have been approved by the DOE to receive such services under EEOICP. The counties in the proposed Service Area are all either locations of DOE worksites or are adjacent counties and are where there is a need for the type of service, dedicated to EEOICP beneficiaries, which the Applicant proposes. Although there are exceptions, home health organizations typically provide services on an episodic basis to Medicare, TennCare and private pay patients. By contrast, the Applicant seeks to serve the more limited population that are EEOICP beneficiaries and who require "private duty" type of services together with the personal support services which Patriot is already licensed to provide. The Applicant is already serving many of these patients with personal support services and seeks to meet the need for additional services to these patients and other EEOICP beneficiaries including the services of RNs, LPNs and CNAs

2. In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. The 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed service area.

   Response: The Applicant does not believe this question is applicable since the services which the Applicant seeks to provide are not intended for the general population. Rather, the proposed services would be limited to those individuals eligible for in-home health care under EEOICP. As a result, the application of the 'need' formula cannot provide an estimate of the need for the in-home health care services with regard to the potential patient population. However, for the sake of completeness, see the Chart attached at Attachment C Need 1 Guidelines for Growth.

3. Using recognized population sources, projections for four years into the future will be used.

Response: The Applicant does not believe this question is applicable since the services which the Applicant seeks to provide are not intended for the general population. Rather, the proposed services would be limited to those individuals eligible for in-home health care under EEOICP. As a result, the application of the 'need' formula cannot provide an estimate of the need for the in-home health care services with regard to the potential patient population. However, for the sake of completeness, see the Chart attached at Attachment C Need 1 Guidelines for Growth.

4. The use rate of existing home health agencies in the county will be determined by examining the latest utilization rate as calculated in the Joint Annual Report of existing home health agencies in the service area. Based on the number of patients served by home health agencies in the service area, estimation will be made as to how many patients could be served in the future.

Response: The Applicant does not believe this question is applicable since the services which the Applicant seeks to provide are not intended for the general population. Rather, the proposed services would be limited to those individuals eligible for in-home health care under EEOICP. As a result, the application of the 'need' formula cannot provide an estimate of the need for the in-home health care services with regard to the potential patient population. However, for the sake of completeness, see the Chart attached at Attachment C Need 1 Guidelines for Growth .

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response Patriot plans to continue growing as the population of EEOICP beneficiaries continues to rise. The Applicant plans to remain local and provide compassionate, personable care to the people in our community that have worked and given up their health to serve our country. The Applicant hopes to grow the business to bring more jobs to the community and have an impact on the unemployment rates. In addition, Patriot intends to become involved in its rural community's activities as well as participate in on the job training programs for local schools.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: Please see a map of the Service Area included as Attachment C Need 3.

4. A. Describe the demographics of the population to be served by this proposal.

Response: Please see chart included as Attachment C Need 4 A which sets forth the current population and the 2019 projected population for the proposed Service Area.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The five counties in the Service Area are all in the east Tennessee area near the DOE Worksites. One of the special needs of the Service Area is that it is the home of many of the EEOICP beneficiaries who are often suffering from serious progressive diseases or conditions as a result of working at the DOE worksites in their area. In addition, much of the Service Area is made up of rural communities making the distance between patients much farther than in more populated areas of the state which makes each home visit require more dedicated hours. The Applicant believes that the distance between patient's homes is typically 25- 30 miles.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: See the Chart at Attachment C Need 5.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Not Applicable. The Application is to establish a new agency. See Letter from Dr. Clary Foote, M.D. P.C. at Attachment C Need 6.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)

   - The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

Response: There are no costs to the project other than the legal costs associated with the application and the filing fee. These costs have either already been paid or will be paid from the cash reserves of the Applicant.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	**$25,0000**
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000)	**$3,000**
	9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	**$6,000**
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)	
	5.	Other (Specify) license fee	**$1,080**
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		**$35,080**
E.	CON Filing Fee		**$3000**
F.	Total Estimated Project Cost (D+E)		
		TOTAL	**$38,080**

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

X E. Cash Reserves--Appropriate documentation from the President and Sole Member and Statement from Suntrust evidencing Patriot's reserves. See Attachment C Economic

__ F. Other—Identify and document funding from all other sources.

Response: Not applicable. There are no ongoing costs for the project. The filing fee will be paid at the time the application is filed and the legal fees associated with the project are anticipated to be paid on an ongoing basis from the Applicant's cash reserves.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: Because this project is for the initiation of home health services, the cost of initiating the services are minimal. The primary cost is the cost of the lease, cost of purchasing additional low cost equipment, such as blood pressure cuffs and the cost of filing this Application which have already been paid or will be paid from operating revenues.

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: The Applicant's charges are set and paid by EEOICP. There will be no difference between gross and net charge. Currently, EEOIC hourly rates for home health services are as follows: Homemaker- $17.04 for up to 8 hours per day & $18.86 for 8 hours or more per day; CNA -$17.53 for up to 8 hours per day & $24.96 for 8 hours or more per day; LPN- $65.75 for up to 8 hours per day & $88.31 for 8 hours or more per day; and RN- $ 82.66 for up to 8 hours per day and $ 110.14 for 8 hours or more per day; and RN Case Manager-$69.80.

HISTORICAL DATA CHART (Not Applicable)

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).*

	Year____	Year___	*Year 2014*
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue – Home Health Services	_____	_____	$_____
Gross Operating Revenue	**$_____**	**$_____**	**$_____**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	**$_____**	**$_____**	**$_____**
NET OPERATING REVENUE	**$_____**	**$_____**	**$_____**
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses (repairs, maintenance, insurance, contract labor, and professional fees).	_____	_____	_____
Total Operating Expenses	**$_____**	**$_____**	**$_____**
E. Other Revenue (Expenses) – Net (Specify)	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	**$_____**	**$_____**	**$_____**
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$ *0*
2. Interest	_____	_____	*0*
Total Capital Expenditures	**$_____**	**$_____**	**$ *0***
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**$**	**$**	**$**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January. (Month)

		Year 2016	Year 2017
A.	Utilization Data (Specify unit of measure)	30 patients	60 patients
B.	Revenue from Services to Patients		
	1. Inpatient Services	$	$
	2. Outpatient Services	$4,256,824	$8,513,648
	3. Emergency Services		
	4. Other Operating Revenue (Specify)		
Gross Operating Revenue		$4,256,824	$8,513,648
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$	$
	2. Provision for Charity Care		
	3. Provisions for Bad Debt		
Total Deductions		$ NA	$ NA
NET OPERATING REVENUE		$ 4,256,824	$8,513,648
D.	Operating Expenses		
	1. Salaries and Wages	$2,042,728	$ 3,889,456
	2. Physician's Salaries and Wages	NA	NA
	3. Supplies	$13,000	$26,000
	4. Taxes	$82,189	$146,358
	5. Depreciation	NA	NA
	6. Rent	6,000	6,000
	7. Interest, other than Capital	NA	NA
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses(Specify)Professional Fees, insurance, Marketing, reserve for unknown contingencies	$10,000	$10,000
	Total Operating Expenses	$ 2,153,917	$ 4,077,814
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		$ 2,102,907	$ 4,435,834
F.	Capital Expenditures		
	1. Retirement of Principal	$	$
	2. Interest		
	Total Capital Expenditures	$ 2,102,907	$ 4,435,834
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 2,102,907	$ 4,435,834

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: All of the Applicant's charges will be paid by EEOICP. See Chart at Attachment C Economic Feasibility 6 which shows the Applicant's anticipated charges at a blended rate of the reimbursement rate for 8 hour and more than 8 hour shifts. There are no co pays or deductibles paid by the beneficiaries.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: The Applicants charges are at the payment rates will be set by the EEOICP. The chart at Attachment C Economic Feasibility 6 shows the charges and costs of the other home health providers in the Service Area who are also EEOICP providers.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: As shown on the Projected Data Chart, the Applicant anticipates a positive net income in the first two years of operation, based on conservative estimates related to growth in second year of operation.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: As shown on the Projected Data Chart, the Applicant anticipates a positive net income in the first two years of operation, with a net operating income of approximately $2,102,907 at the end of year one and $4,435,834 at the end of the second year of operation.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The Applicant's services are paid by the EEOICP. The Applicant does not anticipated participating in any other state or federal programs

10. Provide copies of the balance sheet and income statement from the most recent

reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C Economic Feasibility 10.

Response: Please see copies of the Applicant's Balance Sheet and Income Statement as Attachment C Economic Feasibility 10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: The EEOICP beneficiaries who the Applicant proposes to serve are generally suffering from the effects of debilitating and progressive illnesses. Patriot does not believe there is a more effective way to bring care to them, other than in their own homes. There is no less costly or more effective care available. The alternative to the type of care that the Applicant provides is a nursing home which is not a more effective or cost efficient setting to receive care. While it might be possible for the Applicant to joint venture with an existing home health agency in the Service Area to provide skilled nursing services, it is likely that that option would increase costs and decrease efficiency. The services which the Applicant proposes to provide are different from most home health agencies in a number of ways. It is a combination of personal care/ homemaker services and private duty type nursing. The typical agency provides discrete or episodic services to their patients. In addition, Patriot seeks to provide care to a specific population for which Patriot is already an authorized home health provider. Currently, there are only three EEOICP qualified agencies in the proposed Service Area who are providing private duty type care. As an EEOICP provider, the services are paid by reimbursement received through the Department of Labor, and are on an hourly rate, which varies based on the skill level and amount of time spent with the patient. This is different from reimbursement for Medicare, TennCare and private pay patients, which is primarily based on per visit charges. As a result the services and staffing of an EEOICP provider is different from home health agencies. Patriot will serve fewer patients at a time but will spend more time and provide private duty rather than episodic care. Patriot would also incur additional costs identifying a joint venture partner and coming to an agreement for the provision of services and patients would have to deal with more than one provider as a result a joint venture a more costly alternative and less efficient . Therefore, there are no less costly, more effective or more efficient methods of providing

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: The Applicant considered continuing to provide personal support services and to assist patients who need "private duty" care in finding a home health agency to meet their need but this would require clients to deal with two separate agencies or to seek the alternative of a long term care facility which is less cost efficient and does not allow the patient the option of receiving their care in their home.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response: The Applicant is a contracted provider under EEOICP. In addition, the Applicant anticipates entering into 'working relationships' with providers in its Service Area, including hospitals, hospice organizations and physicians to the extent required to provide the highest quality care to its patients.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: There will be no negative effects of the proposed project on current providers or on the health care system. The combination of "private duty" nursing and homemaker/personal care services which the Applicant will offer to EEOICP beneficiaries differs from those of all but one other agency dedicated to providing in-home health to these individuals. Therefore, the Applicant believes that the Project will have positive effect on the delivery of care and the health care system in the Services Area by offering those eligible for in-home health care under either the EEOICP another choices regarding the provider who can over them both types of care they require. According to statistics from the United States Department of Labor, as of May 25, 2015, there were 14,215 new EEOICP beneficiaries in Tennessee and there is a need for more than one organization to meet that need. The Project will have a positive impact on both the health and lives of eligible beneficiaries, but also on the lives of their family members as well.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: See Chart at Attachment C Contribution to the Orderly Development of Health Care 3.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: The Applicant has not had trouble hiring staff to provide services under its current license and does not anticipate having trouble recruiting and retaining qualified staff. In the Service Area, there are adequate staffing resources for the medical professional staff for the Project. In addition, the Applicant intends to recruit clinical staff from the Technical College of Applied Sciences in Harriman Tennessee.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

Response: The Applicant understands the requirements for licensing. If granted a CON, the Applicant will maintain all requirements of licensing.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

Response: The Applicant hopes to work with Technical College of Applied Sciences in Harriman in their nurse training programs.

7.(a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: The Applicant understands the licensing requirements of the Department of Health and other requirements which are applicable.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response: Licensure: The Applicant will be licensed by the State of Tennessee, Department of Health, and Board for Licensing Health Care Facilities.

Accreditation: None

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: See Attachment C Contribution to the Orderly Development of Health Care. 7(c)

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: See Attachment C Contribution to the Orderly Development of Health Care. 7(d)

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response: None.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

Response: None

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response: The Applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency with relevant information concerning the number of patients treated and such other data as may be required.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response:

A copy of the publication affidavit is provided on the following page.

To: BONE MCALLESTER NORTON PLLC

(Advertising) NOTIFICATION OF INTENT TO APPLY FOR **(Ref No:** 558431)

P.O.#:

PUBLISHER'S AFFIDAVIT

State of Tennessee }

s.s

County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personally came Louise Watkins first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of:

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):
06/05/15 Fri

KAREN DIXON
STATE OF TENNESSEE
NOTARY PUBLIC
BLOUNT COUNTY

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Louise Watkins

Subscribed and sworn to before me this 5th day of June 20 15

Karen Dixon
Notary Public

MY COMMISSION EXPIRES:
June 26, 2017

My commission expires _____ 20____

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that CAMM Care LLC dba Patriot Homecare ("Applicant") owned and managed by CAMM Care LLC dba Patriot Homecare with Caleb Mullins as sole member and with an ownership type of Limited Liability Company and to be self-managed intends to file an application for a Certificate of Need to be licensed to provide home health services in Anderson, Knox, Meigs, Morgan, and Roane counties, at a project cost estimated to be $38,050.00. The Applicant's principal office will be located at 514 Devonia Street, Harriman, Roane County, Tennessee 37748.

The Applicant holds a license from the State of Tennessee Department of Mental Health and Substance Abuse Services to operate a personal support services agency and will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is on or before June 10, 2015. The Applicant's contact person for this project is Anne Sumpter Arney, Attorney, who may be reached at Bone McAllester Norton PLLC, 511 Union Street, Suite 1600, Nashville, Tennessee 37219; (615) 238-6300.

Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled. Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PROOF OF PUBLICATION

Acct. Name:

BONE MCCALLESTER NOR

Acct. # 177330

COST OF PUBLICATION

Total $76.50

STATE OF TENNESSEE

COUNTY OF MCMINN

PERSONALLY appeared before me Ashley Green

_____ of McMinn County, Tennessee.

who being duly sworn, made oath that he/she is a representative of the Publisher of THE DAILY POST-ATHENIAN, a newspaper of general circulation, published in the City of Athens, County of McMinn and State of Tennessee and that the hereto attached publication appeared in the same on the following dates :

NOTIFICATION OF INTENT T

06/05/2015

PLY FOR A CERTIFICATE OF NEED
Health Services and Development
ccordance with T.C.A. § 68-11-1601 *et*
ices and Development Agency, that
e ("Applicant") owned and managed by
e with Caleb Mullins as sole member
Liability Company and to be
ation for a Certificate of Need to be
es in Anderson, Knox, Meigs, Morgan,
estimated to be $38,080.00. The
ed at 514 Devonia Street, Harriman,

State of Tennessee Department of
ervices to operate a personal support
ensed as a home health agency by the
ies.
ation is on or before June 10, 2015. The
act is Anne Sumpter Amey, Attorney,
er Norton PLLC, 511 Union Street, Suite
15) 238-6300.
arties, a local fact-finding public
requests should be sent to:

Development Agency
Building, 9th Floor
erick Street
nnessee 37243

o oppose a Certificate of Need
with the Health Services and
ifteen (15) days before the regularly
lopment Agency meeting at which
ed. Any other person wishing to op-
objection with the Health Services
to the
the Agency.

The Daily Post-Athenian

PO BOX 340, ATHENS, TN 37371

(423) 745-5664

BRITTANY FREEMAN
STATE OF TENNESSEE NOTARY PUBLIC
MCMINN COUNTY

Subscribed and sworn to before me on this 5th day of June, 2015

Newspaper Representative: Ashley Green

Notary Public: [signature]

My Commission Expires: 8-22-17

The referenced publication of notice has also been posted (1) On the newspaper's website, where it shall be published contemporaneously with the notice's first print publication and will remain on the website for at least as long as the notice appears in the newspaper; and (2) On a statewide web site established and maintained as an initiative and service of the Tennessee Press Association as a repository for such notices.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): August____, 2015

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	**DAYS REQUIRED**	**Anticipated Date (MONTH/YEAR)**
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy		
10. *Issuance of license		October 2015
11. *Initiation of service		October 2015
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

Anne Sumpter Arney, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68- 11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Anne Sumpter Arney
SIGNATURE/TITLE

Sworn to and subscribed before me this 9th day of June (Month), 2015 (Year) a Notary Public in and for the County/State of Davidson County, Tennessee.

Kristi Puh
NOTARY PUBLIC

My commission expires 5/3 (Month/Day), 2016 (Year).

ATTACHMENT A 3

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BONE MCALLESTER NORTON PLLC
STE 1600
511 UNION ST
NASHVILLE, TN 37219-1780

Request Type: Certified Copies
Request #: 164336

Issuance Date: 05/29/2015
Copies Requested: 1

Document Receipt

Receipt # : 002077040	Filing Fee:	$20.00
Payment-Check/MO - BONE MCALLESTER NORTON PLLC, NASHVILLE, TN		$20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **CAMM Care LLC**, Control # 752218 was formed or qualified to do business in the State of Tennessee on 04/01/2014. CAMM Care LLC has a home jurisdiction of TENNESSEE and is currently in an Active status. The attached documents are true and correct copies and were filed in this office on the date(s) indicated below.

Tre Hargett
Secretary of State

Processed By: Sheila Keeling

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
A0226-2175	03/25/2014	Initial Filing
B0001-9590	12/31/2014	2014 Annual Report (Due 04/01/2015)
B0050-6745	02/18/2015	Articles of Amendment

ATTACHMENT A 3

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Division of Business Services
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

Control # 000752218
FILED: Mar 25, 2014 7:46PM
DLN # A0226-2175.001
Tre Hargett,
Secretary of State

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: CAMM Care LLC
(Note: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of:

4. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
CHRISTOPHER CALEB MULLINS
423 OAK ST
HARRIMAN, TN 37748-6112
ROANE COUNTY

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is:
Apr 1, 2014 12:00AM **(Not to exceed 90 days)**

7. The Limited Liability Company will be:
☐ Member Managed ☐ Manager Managed ☑ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: Expires: 04/01/2015

10. The complete address of the Limited Liability Company's principal executive office is:
423 OAK ST
HARRIMAN, TN 37748-6112
ROANE COUNTY

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Division of Business Services
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

Control # 000752218
FILED: Mar 25, 2014 7:46PM
DLN # A0226-2175.002
Tre Hargett,
Secretary of State

The name of the Limited Liability Company is: CAMM Care LLC

11. The complete mailing address of the entity (if different from the principal office) is:
423 OAK ST
HARRIMAN, TN 37748-6112

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)
☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)
☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.
Licensed Profession:

14. Series LLC (optional)
☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)
☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: (none)
☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT YOUR ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:
☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions:

Mar 25, 2014 7:46PM	Electronic
Signature Date	Signature
	Christopher C Mullins
Signer's Capacity (if other than individual capacity)	Name (printed or typed)

ATTACHMENT A 3

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

ARTICLES OF AMENDMENT TO ARTICLES OF ORGANIZATION (LLC)

For Office Use Only

LIMITED LIABILITY COMPANY CONTROL NUMBER (IF KNOWN) # 752218

PURSUANT TO THE PROVISIONS OF §48-209-104 OF THE TENNESSEE LIMITED LIABILITY COMPANY ACT OR §48-249-204 OF THE TENNESSEE REVISED LIMITED LIABILITY COMPANY ACT, THE UNDERSIGNED ADOPTS THE FOLLOWING ARTICLES OF AMENDMENT TO ITS ARTICLES OF ORGANIZATION:

PLEASE MARK THE BLOCK THAT APPLIES:

☐ AMENDMENT IS TO BE EFFECTIVE WHEN FILED BY THE SECRETARY OF STATE.

☒ AMENDMENT IS TO BE EFFECTIVE April 1st, 2015 (DATE) 12:00AM (TIME).

(NOT TO BE LATER THAN THE 90TH DAY AFTER THE DATE THIS DOCUMENT IS FILED.) IF NEITHER BLOCK IS CHECKED, THE AMENDMENT WILL BE EFFECTIVE AT THE TIME OF FILING.

1. PLEASE INSERT THE NAME OF THE LIMITED LIABILITY COMPANY AS IT APPEARS ON RECORD: CAMM Care LLC

IF CHANGING THE NAME, INSERT THE NEW NAME ON THE LINE BELOW:

2. PLEASE INSERT ANY CHANGES THAT APPLY:

A. PRINCIPAL ADDRESS: _____ (STREET ADDRESS)

_____ (CITY) _____ (STATE/COUNTY) _____ (ZIP CODE)

B. REGISTERED AGENT: _____

C. REGISTERED ADDRESS: _____ (STREET)

TN (STATE)

_____ (CITY) _____ (ZIP CODE) _____ (COUNTY)

D. OTHER CHANGES: Period of Duration - "Perpetual"

3. THE AMENDMENT WAS DULY ADOPTED ON _____ (MONTH) _____ (DAY) _____ (YEAR)

(If the amendment is filed pursuant to the provision of §48-209-104 of the TN LLC Act, please also complete the following by checking one of the two boxes:) AND THE AMENDMENT WAS DULY ADOPTED BY THE

☐ BOARD OF GOVERNORS WITHOUT MEMBER APPROVAL AS SUCH WAS NOT REQUIRED

☐ MEMBERS

Owner
SIGNER'S CAPACITY

Caleb Mullins
SIGNATURE

Caleb Mullins
NAME OF SIGNER (TYPED OR PRINTED)

SS-4247 (REV. 01/06) Filing Fee: $20.00 RDA 2458

ATTACHMENT A 3

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

CAMM Care LLC
CALEB MULLINS
514 DEVONIA ST
HARRIMAN, TN 37748-2115

June 2, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 752218 Status: Active
Filing Type: Limited Liability Company - Domestic

Document Receipt

Receipt # : 002080446 Filing Fee: $20.00

Payment-Check/MO - BONE MCALLESTER NORTON PLLC, NASHVILLE, TN $20.00

Amendment Type: Assumed Name
Filed Date: 06/02/2015 10:13 AM
Image # : B0098-9500

This will acknowledge the filing of the attached assumed name with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above. The name registration is effective for five years from the date the original registration was filed with the Secretary of State.

Tre Hargett
Secretary of State

Processed By: Cheryl Donnell

Field Name	Changed From	Changed To
New Assumed Name	No Value	Patriot Homecare

ATTACHMENT A 3

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

FILED

Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is: CAMM Care LLC

2. The state or country of organization is: Tennessee

3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.

4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is:

Patriot Homecare

NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.

05/28/2015
Signature Date

CAMM Care LLC
Name of Limited Liability Company

Owner
Signer's Capacity

Caleb Mullins
Signature

Caleb Mullins
Name (typed or printed)

SS-4230 (Rev. 01/06)

Filing Fee: $20.00

RDA 2458

ATTACHMENT A 3

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

BONE MCALLESTER NORTON PLLC
1600
511 UNION STREET
NASHVILLE, TN 37219

June 5, 2015

Request Type: Certificate of Existence/Authorization
Request #: 0164982

Issuance Date: 06/05/2015
Copies Requested: 1

Document Receipt

Receipt # : 002085862

Filing Fee: $22.25

Payment-Credit Card - State Payment Center - CC #: 162950928 $22.25

Regarding: CAMM Care LLC
Filing Type: Limited Liability Company - Domestic
Formation/Qualification Date: 03/25/2014
Status: Active
Duration Term: Perpetual
Business County: ROANE COUNTY

Control # : 752218
Date Formed: 04/01/2014
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

CAMM Care LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 012264527

ATTACHMENT A 6

514 Devonia Street, Harriman, Tennessee

RETAIL LEASE AGREEMENT

THIS LEASE AGREEMENT made and entered into this 23rd day of May, 2014, by and between HATCHER HILL PROPERTIES, LLC., or assigns (referred to as "Landlord"), and CAMM CARE LLC, CALEB MULLINS AND MEGAN MULLINS. (referred to as "Tenant");

WITNESSETH:

1. **Premises:** Landlord hereby leases to Tenant, and Tenant leases and accepts from Landlord, certain premises the Landlord, at 514 Devonia Street, in Harriman, Tennessee containing approximately 1,200 square feet (referred to as "Premises").

   The Premises shall be delivered to Tenant in AS-IS condition.

2. **Term:** The original term of this Lease shall be for a period of One (1) months (the "Base Term") from the "Commencement Date" hereinafter provided unless sooner terminated hereby. Said term shall commence upon execution of this Lease (referred to as "Lease Commencement Date"). Tenant's obligation to pay rent, shall commence on execution of Lease Agreement (referred to as "Rent Commencement Date") or otherwise noted under Special Conditions. After the Base Term the lease shall be month to month.

3. **Minimum Rent:** Tenant shall pay to the Landlord as minimum rent the amounts specified in the Rent Addendum, attached hereto and made a part hereof, without notice, set-off or demand. Rents for each month are due on or before the first of that month. In addition, Tenant agrees to pay a damage deposit equal to one month's rent as shown on the Rent Addendum. Said damage deposit shall be paid at the time this document is executed by Tenant.

4. **Tenant's Use and Operation:** The Demised Premises shall be used and occupied by Tenant solely as a **Home Health Office,** and for no other use without Landlord's prior written consent. Tenant shall be responsible for code compliance in connection with its fixturing and business operation. Tenant shall comply with all rules, regulations and laws of any governmental authority with respect to use and occupancy of the Premises, and shall not violate in any manner any of the exclusive or restrictive use rights granted by Landlord to any other occupants in the Center, which exclusive or restrictive use provisions are available for Tenant inspection. Tenant agrees that it will keep its place of business in the Center open continuously during the term of this Lease on such days and for such hours as shall be compatible with the other stores in the Center, and will not cease operations in said Premises without the express written consent of the Landlord, unless prevented from doing business therein by reason of applicable ordinances or other acts of governmental authorities, or by acts of God, or conditions beyond the control of the Tenant. Tenant may close temporarily for periodic vacations not to exceed two consecutive weeks. If Tenant fails to open the Premises for business on the Rent Commencement Date, fully fixtured, stocked and staffed, then Landlord shall have, in addition to any and all remedies hereinafter provided, the right to immediately terminate this Lease and/or Tenant's right of possession hereunder. Tenant shall not conduct or permit any fire, bankruptcy, auction or "going out of business sale" (whether real or fictitious) in the Premises, or utilize any unethical method of business operation.

   Tenant shall not suffer, allow or permit any vibration, noise, light, odor or other effect to emanate from the Premises,

or from any machine or other installation therein, or otherwise suffer, allow or permit the same to constitute a nuisance or otherwise interfere with the safety, comfort or convenience of Landlord or any of the other occupants of the Warehouse Center or their customers, agents or invitees or any others lawfully in or upon the Center. Upon notice by Landlord to Tenant that any of the aforesaid is occurring, Tenant shall immediately remove or control the same. Tenant shall not use or occupy the Premises or do or permit anything to be done which shall prevent Landlord from obtaining at standard rates any insurance required or desired.

5. **Utilities:** Tenant shall pay promptly, as and when the same shall become due and payable, all rents, rates, and charges for electricity, gas, heat, air conditioning, ventilating, lighting systems, water, wastewater, and other utilities supplying the Premises. Tenant shall be responsible for all utilities serving the Premises from the date the Premises are delivered by Landlord to Tenant for fixturing. Tenant agrees to have all meters serving the Premises placed in Tenant's name upon the date the Premises are delivered to Tenant for fixturing.

6. **Signs:** Tenant shall not place on any exterior door, wall or window of the Premises any sign or advertising matter without first obtaining Landlord's written approval and consent. Tenant agrees to maintain such signs or advertising matter as approved by Landlord in good condition and repair. All signs shall comply with any sign criteria provided by Landlord to Tenant and with applicable ordinances or other governmental restrictions and the determination of such requirements and the prompt compliance therewith shall be the responsibility of the Tenant. All signs of Tenant visible from the common areas of the Center shall be in good taste and shall conform to the standards of design, motif, and decor from time to time uniformly established by Landlord for the Center and the Addendum attached hereto and made a part hereof..

7. **Tenant Improvements:** Tenant must notify Landlord with Tenant's tenant finish selection and both parties must mutually approve such finish selections prior to installation.

8. **Tenant's Duty to Repair; Alterations:** Except for the repairs to be performed by Landlord, Tenant shall keep and maintain in good order, condition and repair (including any such replacement and restoration as is required for that purpose) the Premises and every part thereof and any and all appurtenances thereto wherever located, including, without limitation, the exterior and interior portion of all doors, plate glass, store front, all plumbing and sewage facilities within the Premises including free flow up to the main sewer line, fixtures, and electrical systems (whether or not located in the Demised Premises), walls, floors and ceilings, meters applicable to Tenant's Premises, and all installations made by Tenant under the terms of this Lease and any exhibits thereto, as herein provided. Tenant shall replace all filters on the heating and air conditioning equipment on a timely basis and shall do regular maintenance as recommended by the manufacturer's specifications. Tenant shall not make any alteration of, or addition or improvement to, the Premises without securing the Landlord's prior written consent. Tenant shall save Landlord harmless on account of claims for mechanics', materialmen's or other liens in connection with any work by Tenant, and any such liens shall exist only against Tenant's leasehold interest and shall be discharged, by bond or otherwise, within thirty (30) days after filing. Tenant shall keep and maintain the Premises in accordance with all directions, rules and regulations of the proper officials of the government agencies having jurisdiction, at the sole cost and expense of Tenant, and Tenant shall comply with all requirements of law, by statute, ordinance or otherwise, affecting the Premises and all appurtenances thereto.

9. **Surrender of Premises:** At the termination of the Base Term, or any renewal term thereof, the Tenant does agree to deliver the Premises in the same condition as received by it on the Commencement Date (subject to the removals hereinafter required), reasonable wear and tear excepted, and shall surrender all keys for the Premises to Landlord at the place then fixed for the payment of rent and shall inform Landlord of all combination locks, safes and vaults, if any, in the Premises. Tenant, during the last ten (10) days of such term, shall remove all its trade fixtures, and, to the extent required by Landlord by written notice, any other installations, alterations or improvements, before surrendering the Premises as aforesaid and shall repair any damage to the Premises caused by removal of such items. Tenant's obligation to observe or perform this covenant shall survive the expiration or other termination of the lease term. Any items remaining in the Premises on the termination date of this Lease shall be deemed abandoned for all

purposes and shall become the property of Landlord and the latter may dispose of the same without liability of any type or nature.

10. **Landlord's Duty to Repair:** Landlord shall keep and maintain in good repair the foundation, exterior walls and roof of the building in which the Premises are located and the structural portions of the Premises which were installed by Landlord, exclusive of doors, door frames, door checks, windows, and window frames located in exterior building walls. Landlord shall keep and maintain in good repair the HVAC. Landlord shall not be called upon to make any other improvements or repairs of any kind upon the Premises and appurtenance. Any of the foregoing repairs required to be made by reason of the negligence of Tenant, its agents, employees, invitees, contractors and the like, as above described, shall be the responsibility of the Tenant notwithstanding the provisions above contained in this paragraph.

11. **Liability of Tenant; Insurance:** Tenant shall protect, indemnify and save Landlord harmless from and against all and any liability and expense of any kind, including reasonable attorneys' fees, arising from injuries or damages to persons or property in, on or about the Premises arising out of or resulting in any way from any act or omission of Tenant, its agents, invitees, servants and employees, in the use of the Premises during the term of this Lease. Tenant shall carry public liability insurance covering the Premises and the use and occupancy of the same in a company or companies licensed to do business in Tennessee under a policy satisfactory to Landlord both as to amount and coverage. The policy shall contain a provision that it may not be canceled without first giving Landlord not less than fifteen (15) days prior written notice. Tenant agrees not to keep upon the Premises any articles or goods which may be prohibited by the standard form of fire insurance policy. It is agreed between the parties that in the event the insurance rates applicable to fire and extended coverage insurance covering the within Premises shall be increased by reason of any use of the Premises made by the Tenant, then Tenant shall pay to Landlord such increase in insurance as shall be occasioned by said use. Tenant agrees that if any property owned by it and located in, on or about the Premises shall be damaged or destroyed by any peril, Landlord and the other tenants in the Center shall not have any liability to Tenant, nor to any insurer of Tenant, for or in respect of such damage or destruction, and Tenant shall require all policies of risk insurance carried by it on its property in, on and about the Premises to contain or be endorsed with a provision in and by which the insurer designated therein shall waive its rights of subrogation against Landlord and other such tenants.

12. **Damage or Destruction by Fire or Other Casualty:** If at any time, the Premises become totally untenantable by reason of damage or loss by fire or other casualty and such fire or other casualty shall not have been caused by the negligence or wrongful act or omission of Tenant, Tenant's servants, agents, licensees, or invitees, the rent shall abate until the Premises shall have been restored to tenantable condition, but nothing herein is to be construed as requiring Landlord to restore or rebuild the Premises. If the Premises are so damaged, but not to the extent that they are totally untenantable, Tenant shall continue to occupy same or the tenantable portion thereof, and the rent shall abate proportionately in the ratio that the unusable portion bears to the entire Premises. In the event of a loss from fire or other casualty, Landlord shall have an election not to rebuild or recondition the Premises, which election shall be exercised by written notice thereof to Tenant, given within sixty (60) days from date of said loss. If Landlord exercises such election, this Lease shall cease and terminate, effective on the date of such loss, and Tenant shall pay the accrued rent up to the date of such loss, or Landlord, if the rent has been paid beyond such date, will refund to Tenant the proportionate part of any such rent prepaid, and thereupon this lease shall become null and void, with no further obligation on the part of either party hereto, even though the building may at a later date be rebuilt, restored or reconditioned. No damage or destruction shall allow Tenant to surrender possession of the Premises, nor affect Tenant's liability for the payment of rent, except as specifically provided in this Lease.

13. **Tenant Assignment and Subletting:** Neither Tenant nor any court or officer thereof nor any receiver or trustee in bankruptcy shall assign or transfer this lease or any part thereof, or interest therein, or sublet the Premises or any part thereof without Landlord's prior written consent. Tenant shall always remain liable for any default of any assignee, transferee or subtenant.

14. **Default and Remedies:**

(i) Events of Default. The occurrence of any of the following shall be an Event of Default:

a. Failure by Tenant to pay in full any rent payment or other sum payable hereunder within ten (10) days of the date such payment is due;

b. Failure by Tenant to perform any of the terms or conditions of this Lease, other than the payment of money, for a period of thirty (30) days after notice thereof to Tenant by Landlord;

c. The insolvency of Tenant or the filing by Tenant of a voluntary petition in bankruptcy or for any other relief under the Bankruptcy Act, as amended, or under any other insolvency act, law, rule or regulation, state or federal, now or hereafter existing; the application by Tenant for, or the appointment with Tenant's consent or acquiescence of, a receiver or trustee of Tenant, or for all or a substantial part of the property of Tenant; the making by Tenant of any general assignment for the benefit of creditors of Tenant; or the inability of Tenant, or the admission of Tenant of the inability thereof, to pay the debts of Tenant as such mature;

d. The filing of any involuntary petition against Tenant in bankruptcy or for any other relief under the Bankruptcy Act, as amended, or under any other insolvency act, law, rule or regulation, state or federal, now or hereafter existing; the involuntary appointment of a receiver or trustee of Tenant or for all or for a substantial part of the property of Tenant; or the issuance of attachment, execution or other similar process against any substantial part of the property of Tenant, and the continuation of any of the foregoing for a period of forty-five (45) days undismissed, unbonded, or undischarged; or

e. The abandonment of the Premises as a going business by Tenant for any period exceeding fifteen (15) consecutive days, regardless of whether Tenant continues to pay all rent.

(ii) Remedies. Whenever any Event of Default shall have occurred, Landlord may, to the extent permitted by law, take any one or more of the following remedial steps:

a. Landlord may re-enter and take possession of the Premises without terminating this Lease, and sublease the Premises for the account of Tenant, holding Tenant liable for the difference in the rent and other amounts actually paid by the sublessee and the rents and other amounts payable by Tenant hereunder;

b. Landlord may, as Tenant's agent, without terminating this Lease, enter upon and operate the Premises, and Tenant hereby authorizes Landlord to take over and assume the management of the Premises for Tenant, holding Tenant liable for all amounts payable by Tenant hereunder;

c. Landlord may terminate this Lease, exclude Tenant from possession of the Premises and lease the same to another, holding Tenant liable for all rent and other amounts payable by Tenant hereunder; and/or

d. Landlord may take whatever action is available to Landlord at law or in equity, and in connection with such actions, recover any and all damages to Landlord for Tenant's violation or breach of this Lease.

No remedy herein conferred upon or reserved to Landlord is intended to be exclusive of any other available remedy or remedies, but each and every such remedy shall be cumulative, and shall be in addition to every other remedy given under this agreement or now or hereafter existing at law or in equity or by statute. No delay or omission by Landlord to exercise any right or power accruing upon any default of Tenant shall impair any such right or power or shall be construed to be a waiver thereof, but any such right and power may be exercised by Landlord at any time, from time to time and as often as may be deemed expedient. In order to entitle Landlord to exercise any remedy reserved to it hereunder, it shall not be necessary to give any notice, other than such notice as is expressly required

by this agreement.

In the event that either party shall be required to engage legal counsel for the enforcement of any of the terms of this Lease, whether such employment shall require institution of suit or other legal services required to secure compliance on the part of the defaulting party, the defaulting party shall be responsible for and shall promptly pay to the non-defaulting party the reasonable value of said attorneys' fees, court cost, and any other expenses incurred by the non-defaulting party as a result of such default.

15. **Condemnation:** If a portion of the Demised Premises shall be taken, as herein provided, for public improvements or otherwise, under the exercise of the right of eminent domain and the Premises shall continue to be reasonably suitable for the use which is herein authorized, then the rental herein provided shall be reduced from the date of such taking in direct proportion to the reduction in usefulness of the Premises.

If the real estate hereby leased, or a part thereof sufficient to render the Demised Premises substantially unfit for the use herein authorized, shall be condemned or acquired by grant or otherwise, for the widening of streets or for other public improvements, or shall otherwise be taken in the exercise of the right of eminent domain, Tenant shall have the right, at Tenant's option, to terminate and cancel this Lease on thirty (30) days prior written notice to Landlord, such notice to be given within sixty (60) days of the date of the taking and Tenant shall be liable only for rents and other charges accrued and earned to the date of surrender of possession of the Premises to Landlord and for the performance of other obligations maturing prior to said date.

Tenant shall not be entitled to participate in or receive any part of the damages or award which may be paid to or awarded Landlord by reason of a taking except where said award shall provide for moving or other reimbursable expenses for the Tenant under applicable statute.

16. **Landlord's Right of Entry:** Landlord reserves the right at all reasonable times during the term of this Lease for Landlord or Landlord's agents, upon notice to Tenant, to enter the Premises for the purpose of inspecting and examining the same, and to show the same to prospective purchasers or tenants, and to make such repairs, alterations, improvements or additions as Landlord may deem necessary or desirable. During the ninety (90) days prior to the expiration of the term of this Lease or any renewal term, Landlord may exhibit the Premises to prospective tenants or purchasers, and place upon the Premises the usual notices advertising the Premises for sale or lease, as the case may be, which notices Tenant shall permit to remain thereon without molestation.

17. **Quiet Enjoyment:** Landlord agrees that, if the Rent is being paid in the manner and at the time prescribed and the covenants and obligations of the Tenant are being all and singularly kept, fulfilled and performed, Tenant shall lawfully and peaceably have, hold, possess, use and occupy and enjoy the Premises so long as this Lease remains in force, without hindrance, disturbance or molestation from Landlord, subject to the specific provisions of this Lease.

18. **Subordination and Attornment:** Tenant hereby subordinates all of its right, title and interest in and under this Lease to the lien of any mortgage or mortgages, or the lien resulting from any other method of financing or refinancing, now or hereafter in force against the real estate and/or buildings of which the Demised Premises are a part. In the event of a foreclosure under any mortgage or deed of trust affecting the Premises or the building in which the Premises are located, or in the event of the termination of Landlord's interest or the eviction of Tenant under any ground or other underlying lease, the holder of the Note secured by any mortgage or deed of trust encumbering the Premises, or the purchaser at any foreclosure sale, shall have the option to recognize this Lease, in which event this Lease shall continue in full force and effect. In the event of any sale pursuant to any power of sale granted under any mortgage of deed of trust encumbering the Premises, or conveyance of title to the Premises by deed in lieu of foreclosure, Tenant will attorn to the purchaser of the Premises and its successors and assigns.

19. **Notices:** All notices required or permitted by the terms of this Lease must be given by United States registered or certified mail addressed to Tenant at the Premises and addressed to Landlord at:

Hatcher-Hill Properties, LLC.
311 S. Weisgarber
Knoxville, Tennessee 37919
Attention: Parker Bartholomew

The date when such notice shall be deemed to have been given shall be the date when it is deposited in the United States Mail, postage prepaid, in accordance with the provisions of this paragraph. Any address herein specified may be changed from time to time by either party by written notice given to the other party as above provided.

20. **Successors:** The provisions, covenants and conditions of this Lease shall bind and inure to the benefit of the legal representatives, successors and assigns of each of the parties, except that no assignment or subletting by Tenant without the written consent of Landlord shall vest any right in the assignee or sublessee of Tenant.

21. **Governing Law:** The Lease shall be governed by, and construed in accordance with, the laws of the State where the Premises are located.

22. **Landlord's Exculpatory Clause:** It is specifically understood and agreed that there shall be no personal liability of Landlord in respect to any of the covenants, conditions, or provisions of this Lease. In the event of a breach or default by Landlord of any of its obligations under this Lease, Tenant shall look solely to any right of offset allowed by law against any amounts due hereunder or to the equity of the Landlord in the Center for the satisfaction of Tenant's remedies, it being understood and agreed that the exculpation of Landlord (and its successors and assigns) shall be absolute.

23. **Entire and Binding Agreement:** This Center Lease contains all of the agreements between the parties hereto, and it may not be modified in any manner other than by agreement signed by all parties hereto or their successors in interest. Tenant hereby covenants and agrees not to disclose or discuss with any third party (other than its attorneys, accountants and bona fide investors) the provisions, covenants, and conditions of this Lease without the prior written consent of Landlord. In the event Tenant violates this covenant, Landlord reserves the right to either (i) terminate this Lease, or (ii) revoke any rental or other concessions granted hereunder.

24. **Addenda:** All addenda and exhibits attached hereto are made a part of this Lease for all purposes.

25. **Documentation:** Tenant does covenant and agree to execute and deliver to Landlord within five (5) days from date of request such supplemental documents, including estoppel certificates and financial statements in reasonable form, as may be requested by Landlord. Any such documents may be relied upon by any prospective purchaser or prospective tenant of the Premises, or any lender or prospective lender of Landlord, or any assignee or prospective assignee of any lender thereof. If Tenant fails or refuses to furnish such documents within the time provided, it will be conclusively presumed that this Lease is in full force and effect in accordance with its terms and the Landlord is not in default.

26. **Guarantor(s):** The guarantor executing this Lease, MEGAN MULLINS AND CALEB MULLINS (the "Guarantor" or "guarantor"), hereby guarantees to Landlord, its successors and assigns, the full performance of all obligations of Tenant arising hereunder, whether now existing or hereafter arising. The obligations of the Guarantor shall in no way be terminated, affected or impaired by reason of the assertion by Landlord against Tenant of any of the rights or remedies reserved to Landlord pursuant to the provisions of this Lease, or the granting of any indulgence or extension of time to Tenant, or by reason of the amendment, modification, renewal or extension by Tenant of the Lease, to all of which the Guarantor hereby consents in advance.

27. **Re-execution; Acknowledgment:** Tenant and Guarantor agree that they will, on request of Landlord, re-execute this Lease if necessary to observe any legal formalities (e.g., acknowledgment) required under the laws of the state

where the Premises are located.

28. **Late Payments:** If Tenant fails to pay, when due, any sum payable hereunder, interest will accrue from the date such payment is due at the interest rate generally announced in the Wall Street Journal, or similar publication, as the prime rate, plus two (2%) percent, and such interest together with a late charge of five cents ($0.05) per each dollar so overdue to cover the extra expense involved in handling such delinquency (not as a penalty) shall be paid by Tenant to Landlord at the time of payment of the delinquent sum. If there is no term such as prime rate utilized in the Wall Street Journal, or similar publication, then the rate most nearly similar to such shall be utilized.

29. **Provisions Severable:** If any term or provision of this lease or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this lease, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term and provision of this Lease shall be valid and be enforced to the fullest extent permitted by law.

30. **Hazardous Substances:** Tenant shall not generate, store, treat, dispose of, install or otherwise permit any hazardous substances on, in, or under or in any way related to the Premises, or any other portion of the Shopping Center or cause or permit any such generation, storage, treatment, disposal, installation or other use with respect thereto. Tenant shall fully indemnify and hold Landlord harmless from any liability, damage, cost or expense that Landlord might otherwise suffer from Tenant's failure to fully comply with this provision. This indemnity shall survive expiration or other termination of this Lease. "Hazardous Substances" means and includes any of the substances, materials, elements or compounds that are contained in the list of hazardous substances adopted by the United States Congress, the Environmental Protection Agency, or the Sate of Tennessee, or any substances, materials, elements or compounds affected by any other federal, state, or local stature, law, ordinance, code, rule, regulation, order or decree now or at any time hereafter in effect, regulating, relating to , or imposing liability or standards of conduct concerning any hazardous, toxic, dangerous, restricted or otherwise regulated waste, substance or material.

(Signatures on Next Page)

IN WITNESS WHEREOF, the parties hereto have executed this Lease as of the day and date first above written.

LANDLORD; Hatcher-Hill Properties, LLC

By: _____

Its: Representative

TENANT: CAUM CALE LLC

By: Caleb Mullins Megan Mullins

Its: Owner

GUARANTORS: _____

_____

RENT ADDENDUM (FIXED ESCALATION)

The minimum rent payable by Tenant hereunder shall be as follows:

Lease Years(s)	**Monthly Rent**
Base Term Months __month to month____	$500.00

Landlord Tenant

Initials _____ _____

SIGN ADDENDUM

1. All signs must be submitted in shop drawing form to the Property Manager and Director of Property Management for approval as to type, size, color and design prior to fabrication. Approval shall not be unreasonably withheld for any such sign. Any sign being installed without approval and not meeting with the criteria of the Center will be removed and brought into compliance at the expense of the Tenant. Tenant further agrees to maintain such sign, keep in good condition and repair at all times and will remove the same at the end of the term if requested by the Landlord to do so. Upon removal thereof, Tenant agrees to repair any damage to the Premises caused by such installation.

2. If governmental approval is required, this is the responsibility of Tenant.

3. Signs shall be individual letters. Construction shall be metal channel with plastic face. Each letter shall be internally lighted.

4. No sign is to extend above the top of the fascia or be more than seventy-five percent (75%) of the height of the fascia. Letters shall not be located closer than four and one-half inches (4-1/2") to gutters or bottom of fascia.

5. Specific colors permitted will be as reasonably determined by Landlord.

6. Specific letter style will be as reasonably determined by Landlord.

7. No raceway signs, box signs, uncovered neon signs, etc. will be permitted.

Landlord Tenant

Initials _____ _____

ATTACHMENT B.I.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

CAMM CARE LLC

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Patriot Homecare

(Name of Facility or Service as Known to the Public)

514 Devonia Street, Harriman, TN 37748

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

License Category	Accessible to mobile, non-ambulatory individuals	Approved for persons hearing loss	Approved for persons vision loss	Capacity
Personal Support Services Agency	n/a	n/a	n/a	n/a

April 01, 2015	March 31, 2016	L000000015986
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

ATTACHMENT B I.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
East Tennessee Regional Office of Licensure
520 West Summit Hill Drive Suite 301
KNOXVILLE, TENNESSEE 37902

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

March 06, 2015

Ms. Megan Mullins
Director
CAMM Care LLC
514 Devonia Street
Harriman, TN 37748

Dear Ms. Mullins:

Enclosed is a Full License issued to CAMM Care LLC to operate a facility/service at the address listed herein. This license is effective April 01, 2015 and will expire on March 31, 2016. This Full License indicates that this facility/service has been found to be in full compliance with applicable Licensure rules.

Patriot Homecare at: 514 Devonia Street, Harriman, TN 37748 **Site ID: 4465**
Attached: L000000015986 - Personal Support Services Agency

Also enclosed is a status report for your agency's most recent inspection.

Sincerely,

Cynthia Tyler, Esq.
Director of Office of Licensure

Phone: (865)594-6551 Fax: (844)340-4482

ATTACHMENT B I.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
East Tennessee Regional Office of Licensure
520 West Summit Hill Drive Suite 301
KNOXVILLE, TENNESSEE 37902

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

COMPLIANCE EVENT STATUS REPORT

LICENSEE:	Licensee ID: 1791	FACILITY:	Site ID: 4465
CAMM Care LLC 514 Devonia Street Harriman, TN 37748		Patriot Homecare 514 Devonia Street Harriman, TN 37748	

DATE OF NOTICE / REPORT: 03/06/15
COMPLIANCE EVENT & DATE: **Annual Inspection 1/8/15** Site ID:4465 Event ID:4,897

Gary E. Hancock

Gary E. Hancock, East Tennessee Licensure

No Deficiencies Found

EVENT SUMMARY

09450-5-02 Licensure Administration and Procedures	0 deficiencies
09450-5-38 Personal Support Services Agencies	0 deficiencies

ATTACHMENT B I.

PO Box 8300
London, KY 40742

0000033
CAMM CARE LLC
514 DEVONIA ST

HARRIMAN TN 377482115

Provider ID: 618089000

June 23, 2014

Dear Provider:

Welcome to Affiliated Computer Services (ACS). We are the Central Bill Payment Processing Contractor for the Office of Workers' Compensation Programs (OWCP), Division of Federal Employees Compensation Act (FECA) under the Department of Labor. We are pleased that you have chosen to join us in our efforts to serve the needs of OWCP claimants.

Your DOL FECA provider number is 618089000. Please put this number in block 33 when submitting an OWCP-1500 bill form or block 51 when submitting a UB-92 bill form.

Your provider type is HOME HEALTH AGENCY and, based on the provider enrollment information you provided, you may bill for the following services:

GENERAL HOME HEALTH AGENCY SERVICES

You must bill using the OWCP-1500 form. Enclosed is a guide that explains how to bill for services rendered on the appropriate bill form. It also describes other important information about the Federal Employees Compensation Act and how the Office of Workers' Compensation Program operates.

Thank you for your participation.

ACS - Enrollment Unit
Department of Labor
PO Box 8300
London, KY 40742
1-850-558-1818

ATTACHMENT B I.

PO Box 8304
London, KY 40742

0000001
CAMM CARE LLC
514 DEVONIA ST

HARRIMAN TN 377482115

DEEOIC Provider ID: 618089000

June 23, 2014

Dear Provider:

Welcome to Affiliated Computer Services (ACS). We are the Central Bill Payment Processing Contractor for the Office of Workers' Compensation Programs (OWCP), Division of Energy Employees Occupational Illness Compensation (DEEOIC) under the Department of Labor (DOL). We are pleased that you have chosen to join the program in an effort to provide services to our DEEOIC claimants.

Your DOL DEEOIC provider number is 618089000. Please use this number in block 33 on the OWCP-1500 or in block 51 on the UB-92 billing forms when submitting bills for services performed on behalf of a DEEOIC claimant.

Your provider type is HOME HEALTH AGENCY and, based on the provider enrollment information, you may submit bills for the following services:

GENERAL HOME HEALTH AGENCY SERVICES

You must bill the program using the OWCP-1500 form. Enclosed is a guide that explains how to submit bills for services rendered on the billing form. The guide also describes where to submit bills, the EEOIC toll free number, electronic remittance voucher retrieval and authorization requirements.

Thank you,

ACS - Enrollment Unit
Department of Labor
Division of Energy Employees Occupational
Illness Compensation
PO Box 8304
London, KY 40742
1-866-272-2682

ATTACHMENT B I.

Barbara Megan Mullins

423 Oak Street Harriman, TN 37748 | (865)466-7570 | megan.mullins@live.com

Education

HIGH SCHOOL DIPLOMA | MAY 2005| CENTRAL HIGH SCHOOL

MEDICAL ADMINSTRATIVE ASSISTANT | APRIL 2007 | TENNESSEE COLLEGE OF APPLIDED SCIENCE

A.A.S. CONTEMPORARY MANAGEMENT | AUGUST 2009 | ROANE STATE COMMUNITY COLLEGE

CERTIFIED NURSING ASSISTANT | SEPTEMBER 2012 | TENNESSEE COLLEGE OF APPLIDED SCIENCE

Experience

PATRIOT HOMECARE | DIRECTOR | APRIL 2014 TO CURRENT

- Manage all office and non-skilled field staff
- Maintain all employee & patient information/files according to state requirements
- Calculated and approved payroll
- Interview and hire new employees
- Prepare employees by conducting orientation and monthly in-service training
- Hear and resolve all employee grievances
- Ensure monitoring of employees and provide discipline and praise when needed
- Scheduled all staff accordingly and maintained all vacation request
- Identify potential referral sources and market accordingly
- Planned marketing functions
- Promoted and attended marketing functions in the community
- Made initial contact visits with potential patients
- Maintained an excellent relationship with local physicians
- Coordinate care with the RN Case Manager
- Coordinate with RN Case Manager to identify client needs
- Conduct client survey's as required by state licensure to insure client satisfaction
- Coordinate with physician's office/hospital to coordinate new client care and any changes in client care
- Provide communication to Department of Labor to establish new client care
- Coordinate with RN Case Manager to develop client's Plan of Care
- Manage all aspects of establishing a new client
- Maintain and ordered all supplies
- Oversee and maintain a budget
- Ensure compliance with all state licensure requirements

ADMINISTRATOR | FREEDOM CARE | NOVEMEBER 2012 TO APRIL 2014

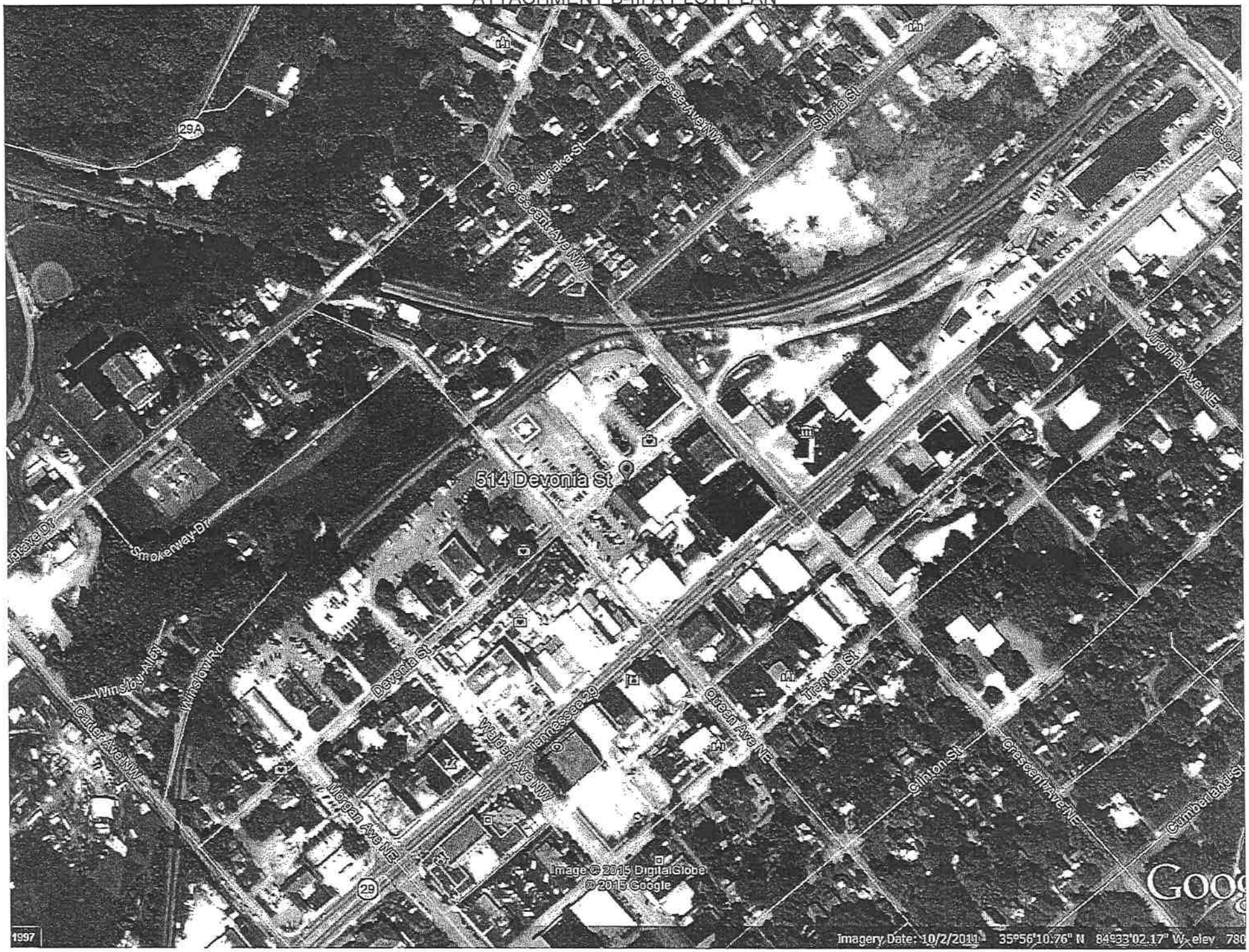
- Manage all office , field nursing staff, and non-skilled field staff
- Maintain all employee & patient information/files according to state requirements
- Calculated and approved payroll
- Interview and hire new employees
- Prepare employees by conducting orientation and monthly in-service training
- Hear and resolve all employee grievances
- Ensure monitoring of employees and provide discipline and praise when needed
- Scheduled all staff accordingly and maintained all vacation request
- Identify potential referral sources and market accordingly
- Planned marketing functions
- Promoted and attended marketing functions in the community
- Made initial contact visits with potential patients
- Maintained an excellent relationship with local physicians

- Coordinate care with RN Case Manager
- Coordinate with RN Case Manager to identify client needs
- Conduct client survey's as required by state licensure to insure client satisfaction
- Coordinate with physician's office/hospital to coordinate new client care and any changes in client care
- Provide communication to Department of Labor to establish new client care
- Coordinate with RN Case Manager to develop client's Plan of Care
- Manage all aspects of establishing a new client
- Maintain and ordered all supplies
- Maintain petty cash and all receipts
- Overseen and maintained a budget in coordination with the home office
- Ensure compliance with all state licensure requirements

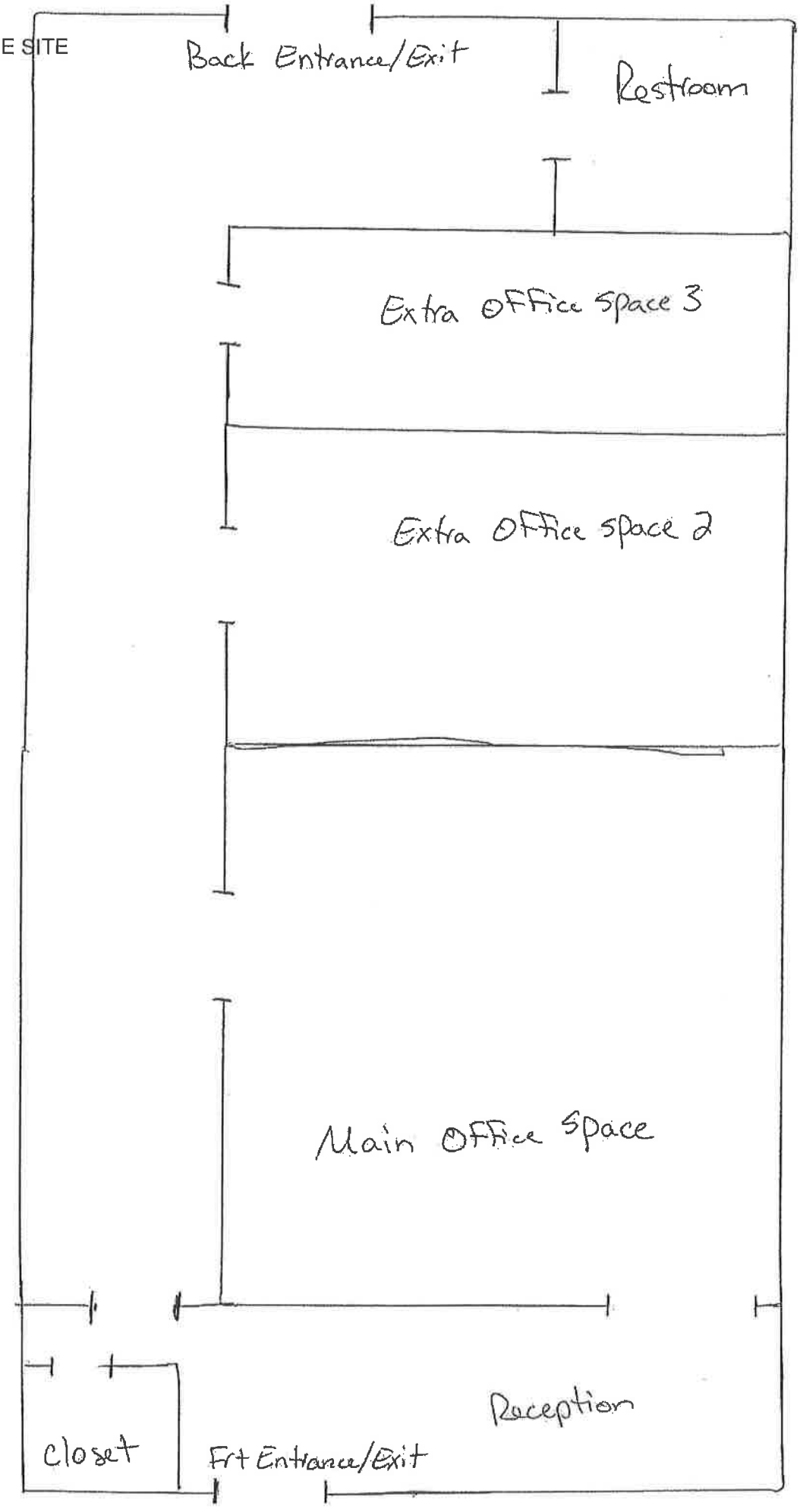
OFFICE MANAGER/MARKETING/CNA | QUALITY PRIVEATE DUTY CARE | DECEMBER 2011 TO NOVERMBER 2012

- Manage an office with approximately 35 field employees
- Maintain all employees information and files to meet state requirments
- Made sure all employees keep paperwork and in services up to date and meet state standards
- Calculated and approved timesheets for payroll
- Identify potential referral sources and market accordingly
- Planned marketing functions
- Promoted and attended marketing functions in the community
- Collect patients medical records as needed for insurance approval
- Did in home visits as a CNA when needed
- Provided excellent care in patient's home
- Reported any changes in patient to appropriate person in a timely manner
- Documented all visits as required
- Took in employment applications
- Performed drug screens for new employees
- Maintain and ordered all supplies
- Report weekly on supplies used
- Maintain petty cash and all receipts
- Report monthly or as needed for petty cash reimbursement

ATTACHMENT B-III A PLOT PLAN



ATTACHMENT B-IV
DRAWING OF OFFICE SITE



[redacted]

June 4, 2015

State of Tennessee
Health Services & Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

I have been accepted with several illnesses with DOL, EEOICPA since 2007. I was approved to receive the benefits of skill nursing (8 hours a day, 5 days a week) and home care services (24 hours a day, 7 days a week) July 2014. I required the services long before I received them. It was a matter of dealing with strangers in my home daily.

Since July 2014, I have had three nurses to come to my home to provide me with RN services 8 hours a day, five days a week; this working with two separate providers. The first provider worked for herself and it was difficult for her to work without oversight and had no one to replace her the times she was not able to show up. The next two proved to be untrustworthy and unhealthy to be in my home. These providers did not care about my well fare only that they were able to bill off me. Currently, I only receive RN case management with my personal care services through Patriot; which means, I am presently without nursing care.

I am hoping and praying that Patriot will be awarded the opportunity to provide Nursing as well as the home makers; which they are doing an outstanding job with integrity and the personal care they give each patient. This year has been difficult having to deal with two different providers. I know from my personal experience that it would be easier on the patient if services were under one provider that cares and is serious about taking care of the patient. I keep my physicians informed and they are concern about certain providers misusing patients in this program. My physicians work willingly with Patriot on my behalf without disappointment.

My phone is constantly ringing where word is out that I have accepted conditions with DOL; different providers call who has partnered with the union or lawyers to grab up approved patients for their own benefit. I know I can trust Patriot to care for me. If you should have any questions, feel free to contact me any time on my cell which is [redacted] or my home number which is [redacted].

Respectfully,

[redacted]

cc: Dr. Bridgeman

I concur with the above.
Pamela A. Bridgeman, MD

Summit Medical Group of Oak Ridge
301 Oak Ridge Turnpike
Oak Ridge, TN 37830

ATTACHMENT C NEED 1 (1)

May 27, 2015

To Whom It May Concern:

I am writing this letter in regards to Patriot Homecare. Patriot Homecare currently provides me with personal care services through Department of Labor. I know in the future I will need nursing care as my disease progresses and would want my care to be provided through Patriot Homecare. I think that it would be a hassle and go against my health to have to deal with more than one company to provide my healthcare. Patriot Homecare is very knowledgeable about Department of Labor and has taken the stress off of me when it comes to my care. I know that I couldn't find a more caring, personable company to provide my care. They go above and beyond to make sure every one of my needs are met.

I sincerely hope that they can provide my skilled nursing care when the time comes. I couldn't ask for more compassionate people to provide my care.

Sincerely,

ATTACHMENT C NEED 1 (1)

June 4, 2015

I currently receive personal care services through Patriot Homecare. I am in need of nursing services but have been too leery of trying to obtain them through another company because of other family member's experiences. I hope that Patriot can become licensed and provided my nursing services. They have been very caring and helpful with everything that I have needed. They always go above and beyond to make sure all of my needs are met and make me feel like I am their only patient. They are also very knowledgeable about Department of Labor which has helped me a great deal. I hope that this is a service they can provide as I know that I am in need now but do not want to deal with another company.

Sincerely,

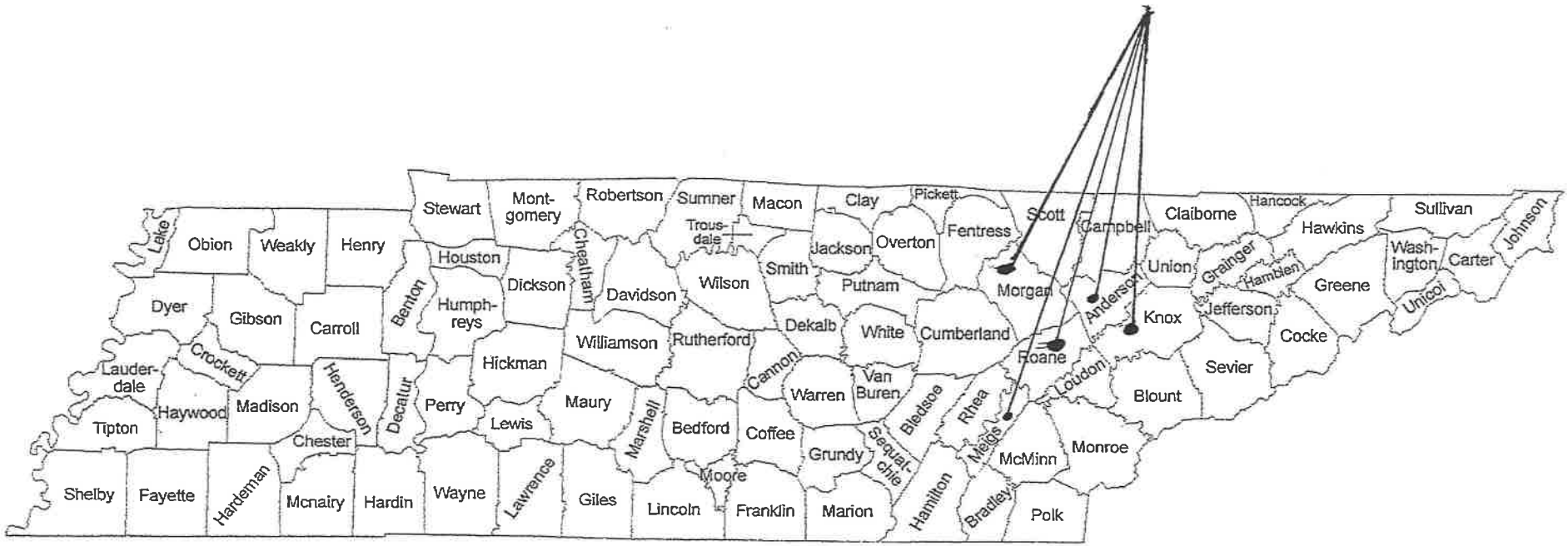
ATTACHMENT C NEED 1 GUIDELINES FOR GROWTH

Home Health Need Formula in the Applicant's 5-County Service Area

a	b	c	d	e	f	g	h	
County	Number of Authorized Agencies	2015 Population	Patients Served (2014)	Use Rate (Patient/1000 population)	2019 Population	Projected Capacity	Projected Need	Additional Need (Surplus)
Anderson	20	76,949	2,618	3.40%	78,123	2,658	1,172	1,486
Knox	23	459,124	8,802	1.92%	481,044	9,222	7,216	2,007
Meigs	19	12,331	360	2.92%	12,697	371	190	180
Roane	21	54,079	2,215	4.10%	54,631	2,238	819	1,418
Morgan	21	21,870	526	2.41%	22,076	531	331	200
TOTALS	104	624,353	14,521	2.33%	648,571	15,084	9,729	5,356

ATTACHMENT C NEED 3

MAP OF PROPOSED SERVICE AREA



ATTACHMENT C NEED 4 A

Demographic Characteristics of Project Service Area

2015-2019

Demographic	Anderson County	Knox County	Meigs County	Morgan County	Roane County	Service Area Total	State of Tennessee
Median Age - 2010 US Census	42.6	35.7	42.9	39.8	44.9	41.18	38
Total Population - 2015	76,949	459,124	12,331	21,870	54,079	624,353	6,649,438
Total Population - 2019	78,123	481,044	12,697	22,076	54,631	648,571	6,894,997
Total Population - % Change 2015 to 2019	1.5%	4.8%	3.0%	0.9%	1.0%	3.9%	1.5%
Age 65+ Population - 2015	14,986	69,186	2,560	3,531	11,701	101,964	1,012,937
% of Total Population	19.5%	15.1%	20.8%	16.1%	21.6%	16.3%	15.2%
Age 65+ Population - 2019	16,737	81,757	2,869	3,697	12,863	118,123	1,134,565
% of Total Population	21.4%	17.0%	22.6%	17.7%	23.5%	18.2%	16.5%
Age 65 + Population - % Change 2015 - 2019	11.7%	18.2%	12.1%	10.4%	9.9%	15.8%	12.0%
Age 18-64 Population - 2015	46,611	293,133	7,442	14,136	31,982	393,304	4,124,968
% of Total Population	60.6%	63.8%	60.4%	64.6%	59.1%	63.0%	62.0%
Age 18-64 Population - 2019	46,577	300,035	7,607	14,086	31,864	400,169	4,228,749
% of Total Population	59.6%	62.4%	59.9%	63.8%	58.3%	61.7%	61.3%
Age 0-17 Population - 2015	15,352	96,805	2,329	4,203	10,396	129,085	1,511,533
% of Total Population	20.0%	21.1%	18.9%	19.2%	19.2%	20.7%	22.7%
Age 0-17 Population - 2019	14,809	99,252	2,221	4,093	9,904	130,279	1,531,683
% of Total Population	19.0%	20.6%	17.5%	18.5%	18.1%	20.1%	22.2%
Age 0-17 Population - % Change 2015-2019	-3.5%	2.5%	-4.6%	-2.6%	-4.7%	0.9%	1.3%
Median Household Income - 2013	$40,689.00	$47,694.00	$35,150.00	$37,631.00	$42,223.00	$40,677.40	$44,298.00
TennCare Enrollees (11/14)	15,255	69,518	2,907	4,531	10,662	102,868	1,324,208
Percent of 2014 Population Enrolled in TennCare	19.8%	15.1%	23.6%	20.7%	19.7%	16.5%	19.9%
Persons Below Poverty Level	13,478	61,992	2,380	3,936	7,948	89,734	1,159,611
Persons Below Poverty Level as % of Population (US Census)	17.5%	13.5%	19.3%	18.0%	14.7%	14.4%	17.4%

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics; U.S. Census Quickfacts; Bureau of TennCare

ATTACHMENT C NEED 5

Existing Licensed HHAS & Their Utilization Serving the 5-County Declared Service Area--Alphabetical by Agency Name

Agency License #	Date Licensed	County of Parent Office	Total Counties Authorized in License	Agency Name	2012 JAR Total Patients Served	2013 JAR Total Patients Served	2014 JAR Total Patients Served
150	8/2/1984	Knox	28	Amedisys Home Health Care	3,347	3,456	2,693
113	7/01/1981	Hamilton	20	Amedisys Home Health	84	92	57
191	1/17/1984	Overton	11	Amedisys Tennessee, L.L.C.	21	31	27
213	6/6/1984	Blount	19	Blount Memorial Hospital Home Health Services	13	9	9
144	9/7/1978	Knox	28	Camellia Home Health of East Tennessee	740	721	688
131	8/21/1989	Knox	6	CareAll Home Care Services	233	425	530
83	1/29/1976	Franklin	35	Caresouth HHA Holdings of Winchester, LLC	0	1	6
1	10/26/1976	Anderson	7	Clinch River Home Health	445	411	430
98	5/7/1976	Hamilton	8	Continucare Healthservices, Inc. - 1	13	8	5
133	7/14/1978	Knox	17	Covenant Homecare	2,395	2,366	2,889
132	9/13/1984	Knox	16	East Tennessee Children's Hospital Home Health Care	284	314	288
42	7/17/1984	Davidson	95	Elk Valley Health Services LLC	17	20	10
211	9/20/1985	Scott	5	Elk Valley Home Health Care Agency, LLC	11	13	33
13	1/10/1984	Bradley	5	Family Home Care, Cleveland	39	27	62
142	11/28/1977	Knox	16	Gentiva Health Services	661	559	256
100	8/24/1984	Hamilton	12	Gentiva Health Services	1	1	2
149	8/15/1984	Knox	27	Gentiva Health Services	486	721	828
115	6/29/1978	Hamilton	7	Guardian Home Care, LLC	56	51	53
56	09/07/1988	Davidson	95	Home Care Solutions	233	299	239
338	11/14/1996	Hamilton	10	Home Care Solutions	6	4	3
168	10/1/1980	McMinn	4	Home Care Solutions-Etowah	8	10	1
14	3/14/1984	Bradley	17	Home Health Care of East Tennessee, Inc.	20	9	4
148	12/13/1984	Anderson	6	Home Option by Harden Health Care	1	25	8
190	9/10/1984	Monroe	15	Intrepid USA Healthcare Services	221	300	285
109	11/7/1984	Hamilton	10	Life Care at Home of Tennessee	10	9	5
2	6/20/1984	Knox	18	Maxim Healthcare Services, Inc.	21	28	20
103	8/9/1982	Hamilton	11	Memorial Hospital Home Health	2,835	17	17
143	06/10/1977	Knox	15	NHC Homecare	510	552	764
166	2/13/1984	McMinn	8	NHC Homecare	18	15	30
208	5/17/1976	Rutherford	24	NHC Homecare	1	2	2
10	5/16/1984	Hamblen	30	Premier Support Services, Inc.	8	7	8
620	1/30/2008	Anderson	8	Professional Case Management of Tennessee	151	133	134
287	3/7/1984	Fentress	16	Quality Home Health	1,007	962	1,101
80	10/28/1983	Fentress	5	Quality Private Duty Care	3	9	8
16	8/10/1984	Campbell	10	Sunbelt Homecare	35	10	17
189	8/20/1984	Monroe	5	Sweetwater Hospital Home Health	43	51	51
151	2/29/1980	Knox	15	Tennova Home Health	2,113	1,988	1,834
156	7/20/1983	Knox	16	University of TN Medical Center Home Care Services – Home Health	1,688	1,706	366
				TOTALS	17,778	15,362	13,763

Source: TDH HHA Joint Ann. Reports, 2012-2014

ATTACHMENT C NEED 6

Dr. Clary Foote, M.D., P.C.
190 North Roane Street
Harriman, Tn 37748
Ph: 865-882-2800
Fax: 865-882-3512

April 13, 2015

Clary Foote, MD
190 N Roane Street
Harriman, TN 37748
P: (865)882-2800

Tennessee Health Services Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

To Whom it May Concern:

I am writing this letter on behalf of CAMM Care LLC dba Patriot Homecare. Patriot Homecare currently provides personal care services to my patients. I will continue to be a referral source to them in support of them pursing their Certificate of Need. This will allow my patients to receive all of their care from one source and will allow us to work together to provide a more focused plan of care without the hassle and inconvenience of having multiple companies involved in their care. I believe this will also improve on the quality of care that my patients receive.

This is a much needed service in our area and I believe CAMM Care LLC dba Patriot Homecare will continue to provide quality, compassionate care to my patients. If I can be of any more assistance, please feel free to contact our office.

Sincerely,

Clary Foote, MD

Patriot Homecare
514 Devonia Street
Harriman, TN 37748
P: (865)234-7007
F: (865)-234-7020
July 2, 2015

State of Tennessee
Health Services and Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

I am the President and sole member of CAMM care, LLC. and CAMM care, LLC has already paid the majority of the project costs associated with its Application for a Certificate of Need to provide home health services and has adequate reserves to provide the remainder of the project costs.

Sincerely,

Caleb Mullins

SUNTRUST BANK
PO BOX 305183
NASHVILLE TN 37230-5183

SunTrust

Account Statement

CAMM CARE LLC
514 DEVONIA ST
HARRIMAN TN 37748-2115

Questions? Please call
1-800-786-8787

HOW CAN WE HELP YOU MAKE THE RIGHT FINANCIAL CHOICES FOR TODAY AND TOMORROW?
WITH OUR VARIETY OF SOLUTIONS AND FINANCIAL GUIDANCE.
WE VALUE YOU AS A CLIENT AND WANT TO HELP YOU BANK THE WAY THAT FITS YOUR LIFE.
LEARN MORE AT SUNTRUST.COM.

Account Summary

Account Type	Account Number	Statement Period
PRIMARY BUSINESS CHECKING	[redacted]	05/01/2015 - 05/31/2015

Description	Amount	Description	Amount
Beginning Balance	$2,674.56	Average Balance	$18,370.32
Deposits/Credits	$89,034.64	Average Collected Balance	$17,980.16
Checks	$18,934.87	Number of Days in Statement Period	31
Withdrawals/Debits	$33,454.92		
Ending Balance	$39,319.41		

Deposits/ Credits

Date	Amount	Serial #		Date	Amount	Serial #	
05/05	735.00		DEPOSIT	05/14	1,155.00		DEPOSIT
05/08	735.00		DEPOSIT	05/28	3,000.00		DEPOSIT
05/13	5,080.88		DEPOSIT				

05/07	15,342.50	*ELECTRONIC/ACH CREDIT* EEOI TREAS 310	MISC PAY	618089000161500
05/14	23,689.60	*ELECTRONIC/ACH CREDIT* EEOI TREAS 310	MISC PAY	618089000161500
05/21	18,568.18	*ELECTRONIC/ACH CREDIT* EEOI TREAS 310	MISC PAY	618089000161500
05/28	22,730.48	*ELECTRONIC/ACH CREDIT* EEOI TREAS 310	MISC PAY	618089000161500

Deposits/Credits: 9 Total Items Deposited: 8

Checks

Check Number	Amount	Date Paid	Check Number	Amount	Date Paid	Check Number	Amount	Date Paid
298	100.00	05/26	327	924.00	05/15	340	924.00	05/21
*310	420.00	05/04	328	840.00	05/14	341	840.00	05/22
*316	500.00	05/06	329	924.00	05/15	342	400.00	05/21
317	164.20	05/07	330	400.00	05/14	343	924.00	05/22
318	401.75	05/08	331	401.75	05/11	344	401.75	05/19
319	560.39	05/05	332	560.39	05/11	345	560.38	05/20
320	420.00	05/13	333	150.00	05/26	*347	924.00	05/28
321	924.00	05/13	334	145.33	05/18	348	840.00	05/28
322	840.00	05/08	335	250.00	05/19	349	400.00	05/28
323	924.00	05/08	336	130.86	05/15	*351	401.75	05/26
324	59.15	05/26	337	60.88	05/13	352	560.39	05/26
325	211.60	05/20	338	586.50	05/13			
326	420.00	05/20	339	420.00	05/26			

Checks: 37 *Break in check sequence

ATTACHMENT C ECONOMIC FEASIBILITY 6

Cost Per Visit			
Agency*	Skilled Nursing Care	Homemaker Services	Home Health Aide Service
1	$46	$0	$18
2	$110	$0	$30
3	$175	$0	$41
4	$153	NA	$114
5	$123	NA	$66
6	NA	$0	$0
7	NA	$0	$0
8	$84	$0	$40
9	$163	$0	$44
10	$93	NA	$44
11	$121	NA	NA
12	NA	NA	NA
Average Charge Per Visit			
Agency*	Skilled Nursing Care	Homemaker Services	Home Health Aide Service
1	NA	NA	NA
2	NA	NA	NA
3	$160	$0	$75
4	NA	NA	NA
5	NA	NA	NA
6	NA	$0	$0
7	$1,260	$238	$252
8	NA	$0	$0
9	NA	$0	$0
10	NA	NA	NA
11	NA	NA	NA
12	NA	NA	NA
Average Charge Per Hour			
Agency*	Skilled Nursing Care	Homemaker Services	Home Health Aide Service
1	NA	NA	NA
2	NA	NA	NA
3	$24	$22	$0
4	NA	NA	NA
5	NA	NA	NA
6	NA	$0	$21
7	$90	$17	$18
8	NA	$0	$0
9	NA	$0	$0
10	NA	NA	NA
11	NA	NA	NA

12	$77.03	$17.95	$21.25

Source: 2014 Joint Annual Reports, Hero Healthcare, LLC Management and United States Department of Labor, Office of Workers' Compensation Programs

*Key to Agencies:

1. Amedysis Home Health Care (Knox; ID 47202)
2. Blount Memorial Home Services (Blount; ID 05012)
3. Camellia Home Health (Knox; ID 47062)
4. Clinch River Home Health (Anderson; ID 01032)
5. Covenant Homecare & Hospice (Knox; ID 47402)
6. Professional Case Management of Tennessee (Anderson; ID 01042)
7. The Home Option by Harden Health Care (Knox; ID 47372)
8. Sunbelt Homecare (Campbell; ID 07032)
9. Tennova Home Health (Knox; ID 47092)
10. University of Tennessee Medical Center Home Care Services (Knox; ID 47132)
11. Gentiva Health Services (Knox; ID 47042)
12. Patriot Proposed Agency**

CAMM CARE LLC
Statement of Assets, Liabilities & Equities-Income Tax Basis
As of January 1, 2015

	Jan 1, 15
ASSETS	
Current Assets	
Checking/Savings	66,218.67
Other Current Assets	40.00
Total Current Assets	66,258.67
TOTAL ASSETS	**66,258.67**
LIABILITIES & EQUITY	
Equity	66,258.67
TOTAL LIABILITIES & EQUI...	**66,258.67**

CAMM CARE LLC
Statement of Revenues and Expenses - Income Tax Basis
January through December 2015

	Jan - Dec ...
Ordinary Income/Expense	
Income	
Gross Income	211,913.49
Total Income	211,913.49
Gross Profit	211,913.49
Expense	
OPERATING EXPENS...	130,791.25
Total Expense	130,791.25
Net Ordinary Income	81,122.24
Net Income	**81,122.24**

ATTACHMENT C CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE 3

Position	No. of Full Time Equivalent Employees	1st Year	2nd Year	Applicant's Planned Salary/Wage Range	Prevailing Wage for this type of Employee
Administrator	1	1	1	$40,000/year	$68,343/year*
Director of Nursing	1	1	1	$80,000/year	$51,631/year
Contracted RNs	2	2	2	$30/hour	$24/hour
Staff LPNs	15	15	15	$26/hour	$17/ hour
Certified Nursing Assistant	10	10	10	$11/hour	$10/hour
Personal Care Attendant	30	30	30	$10/hour	$10/hour
Marketing Director	1	1	1	$50,000/year	$77,768/year
Receptionist	1	1	1	$26,000/year	$21,985/year
Total	61	61	61	---------	----------

ATTACHMENT C CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE 7(c)

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
East Tennessee Regional Office of Licensure
520 West Summit Hill Drive Suite 301
KNOXVILLE, TENNESSEE 37902

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

March 06, 2015

Ms. Megan Mullins
Director
CAMM Care LLC
514 Devonia Street
Harriman, TN 37748

Dear Ms. Mullins:

Enclosed is a Full License issued to CAMM Care LLC to operate a facility/service at the address listed herein. This license is effective April 01, 2015 and will expire on March 31, 2016. This Full License indicates that this facility/service has been found to be in full compliance with applicable Licensure rules.

Patriot Homecare at: 514 Devonia Street, Harriman, TN 37748 **Site ID: 4465**
Attached: L000000015986 - Personal Support Services Agency

Also enclosed is a status report for your agency's most recent inspection.

Sincerely,

Cynthia Tyler, Esq.
Director of Office of Licensure

Phone: (865)594-6551 Fax: (844)340-4482

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

CAMM CARE LLC

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Patriot Homecare

(Name of Facility or Service as Known to the Public)

514 Devonia Street, Harriman, TN 37748

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

License Category	Accessible to mobile, non-ambulatory individuals	Approved for persons hearing loss	Approved for persons vision loss	Capacity
Personal Support Services Agency	n/a	n/a	n/a	n/a

April 01, 2015	March 31, 2016	L000000015986
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

ATTACHMENT C CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE 7(d)

JUN 5 PM 1:15

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
East Tennessee Regional Office of Licensure
520 West Summit Hill Drive Suite 301
KNOXVILLE, TENNESSEE 37902

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

COMPLIANCE EVENT STATUS REPORT

LICENSEE: Licensee ID: 1791 CAMM Care LLC 514 Devonia Street Harriman, TN 37748	**FACILITY:** Site ID: 4465 Patriot Homecare 514 Devonia Street Harriman, TN 37748

DATE OF NOTICE / REPORT: 03/06/15
COMPLIANCE EVENT & DATE: **Annual Inspection 1/8/15** Site ID:4465 Event ID:4,897

Gary E. Hancock

Gary E. Hancock, East Tennessee Licensure

No Deficiencies Found

EVENT SUMMARY

09450-5-02 Licensure Administration and Procedures	0 deficiencies
09450-5-38 Personal Support Services Agencies	0 deficiencies

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

July 1, 2015

Anne S. Arney, Esq.
Bone Mcallester Norton, PLLC
511 Union St Suite 1600
Nashville, TN 37219

RE: Certificate of Need Application -- CAMM Care LLC d/b/a Patriot Homecare -CN1506-023
To establish a home health agency imited to Energy Employees Occupational Illness Compensation Program Act (EEOICPA) patients which is administered by the United States Department of Labor. The parent office will be located at 514 Devonia Street, Harriman (Roane County), Tennessee. The service area consists of Anderson, Knox, Meigs, Morgan, and Roane counties. The estimated project cost is $41,080.

Dear Ms. Arney:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on July 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on September 23, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: July 1, 2015

RE: Certificate of Need Application
CAMM Care LLC d/b/a Patriot Homecare - CN1506-023

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on July 1, 2015 and end on September 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Anne S. Arney, Esq.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Knoxville News Sentinel and The Daily Post Athenian (Name of Newspaper) which is a newspaper of general circulation in Anderson, Knox, Morgan, Roane and Meigs (County), Tennessee, on or before June 5 (Month / day), 20 15 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

CAMM Care LLC dba Patriot Homecare (Name of Applicant) N/A (Facility Type-Existing)

owned by: Caleb Mullins with an ownership type of limited liability company

and to be managed by: self-managed intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: to be licensed to provide home health services in Anderson, Knox, Meigs, Morgan and Roane counties, at a project cost estimated to be $38,080. The Applicant's principal office will be located at 514 Devonia Street, Harriman, Roane County, Tennessee 37748.

At this time, the Applicant holds a license from the State of Tennessee Department of Mental Health and Substance Abuse Services to operate a personal support services agency and will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is: June 10, 20 15

The contact person for this project is Anne Sumpter Arney (Contact Name) Attorney (Title)

who may be reached at: Bone McAllester Norton, PLLC (Company Name) 511 Union Street, Suite 1600 (Address)

Nashville (City) Tennessee (State) 37219 (Zip Code) 615 / 238-6300 (Area Code / Phone Number)

Anne Sumpter Arney (Signature) 4/8/2015 (Date) asarney@bonelaw.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

CAMM Care LLC dba Patriot Homecare (Name of Applicant), N/A (Facility Type-Existing)

owned by: Caleb Mullins with an ownership type of limited liability company

and to be managed by: self-managed intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: to be licensed to provide home health services in Anderson, Knox, Meigs, Morgan and Roane counties, at a project cost estimated to be $38,080. The Applicant's principal office will be located at 514 Devonia Street, Harriman, Roane County, Tennessee 37748. The Applicant holds a license from the State of Tennessee Department of Mental Health and Substance Abuse Services to operate a personal support services agency and will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is: June 10, 20 15

The contact person for this project is Anne Sumpter Arney (Contact Name), Attorney (Title)

who may be reached at: Bone McAllester Norton, PLLC (Company Name), 511 Union Street, Suite 1600 (Address)

Nashville (City), Tennessee (State), 37219 (Zip Code), 615 / 238-6300 (Area Code / Phone Number)

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that CAMM Care LLC dba Patriot Homecare ("Applicant") owned and managed by CAMM Care LLC dba Patriot Homecare with Caleb Mullins as sole member and with an ownership type of Limited Liability Company and to be self-managed intends to file an application for a Certificate of Need to be licensed to provide home health services in Anderson, Knox, Meigs, Morgan, and Roane counties, at a project cost estimated to be $38,080.00. The Applicant's principal office will be located at 514 Devonia Street, Harriman, Roane County, Tennessee 37748.

The Applicant holds a license from the State of Tennessee Department of Mental Health and Substance Abuse Services to operate a personal support services agency and will seek to be licensed as a home health agency by the Board for Licensing Health Care Facilities.

The anticipated date of filing the application is on or before June 10, 2015. The Applicant's contact person for this project is Anne Sumpter Arney, Attorney, who may be reached at Bone McAllester Norton PLLC, 511 Union Street, Suite 1600, Nashville, Tennessee 37219; (615) 238-6300.

Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled. Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SUPPLEMENTAL - #1 ORIGINAL

Patriot Homecare

CN1506-023

BONE MCALLESTER NORTON PLLC

SUPPLEMENTAL

Anne Sumpter Arney
615.238-6360 Phone
615.687.2764 Fax
asarney@bonelaw.com

June 23, 2015

Mr. Phillip Earhart
HSD Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
Nashville, Tennessee 37242

Re: Certificate of Need Application CN1506-023
CAMM Care LLC d/b/a Patriot Homecare

Dear Phillip:

The responses below are to reply to your letter dated June 17, 2015. This letter is being submitted in triplicate.

1. Section B, Project Description, Item 1

Please clarify if a family member can be reimbursed for personal care services reimbursed through the EEOICPA program. If so, are EEOICPA patients and family members aware of this arrangement?

Response: A family member can be reimbursed through the EEOICPA program for personal care services only if they are a trained personal care attendant and can only be approved to provide up to 12 hours of care a day. The Applicant does not know whether or not EEOICPA patients and family members are aware of this arrangement and believes that the family member would have to provide the care through a company that was EEIOCPA qualified. To its knowledge, none of the Applicant's current clients have family members who are trained as personal care attendants and the Applicant believes that it is unlikely that many of its potential patients have family members who are trained personal care attendants. In addition, the family member would have to be trained to meet the billing and certification requires of EEOICPA.

Are there any best practice guidelines that recommend the integration of EEOICPA home health and personal care services by the same provider to one patient?

Response: To the Applicant's knowledge, there are no best practice guidelines concerning integration of EEOICPA home health and personal care services by the

Nashville City Center, Suite 1600 - 511 Union Street - Nashville, Tennessee 37219
615.238.6300 (Phone) - 615.238.6301 (Fax)

same provider to one patient; however, the Applicant believes such integration would contribute to the orderly development of health care and benefit the quality of a patient's care and life. First, a patient would only have to engage a single care provider so there would be less time and paperwork for the patient involved for the patient to receive care. In addition, a single provider would be more fully informed on the various aspects of the patient's care which would contribute to more timely communication among caretakers and nurses and less unnecessary overlap in services. A single provider for one patient is also much easier for their physician since he must certify he patient's need for each provider and this requires a face to face visit for each certification. A single provider would be less confusing for the patient and more efficient for the patient, the physician and the providers. In addition, EEOICPA does not favor a patient having more than one provider for the same class of services because it requires that they process more claims and doubles their work.

How is consumer choice of providers protected if both EEOICPA home health and personal care services are provided by the same provider?

Response: The patient would continue to be able to choose which ever EEOICPA approved agency they wanted for each, and any aspect of their care. The project would contribute to consumer choice by giving patients more than one choice for home health services that includes private duty and personal care/homemaker services.

The Letter of Intent filed by the applicant seeks to be licensed as a home health agency. Please clarify if the applicant seeks a Certificate of Need restricted to home health services to EEOICPA patients reimbursed by United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program (EEOICPA).

Response: The Applicant seeks a Certificate of Need restricted to home health services to EEOICPA patients reimbursed by United States Department of Labor, Division of Energy Employees Occupation Illness Compensation Program (EEOICPA).

It is noted as of May 25, 2015, there were 14,215 new EEOICPA beneficiaries in Tennessee. Please address the following:

1. Please provide documentation to verify there are 14,215 new Tennessee EEOICPA beneficiaries.

   Response: The Applicant should have said that according to the statistical data of the U.S. Department of Labor ("DOL") Office of

Workers Compensation Programs, Division of Energy Employees Occupational Illness Compensation Program Statistics, found on the EEOICPA s website, there were a total of 14,215 Part B and E approved cases filed as of 5/25/2015. http://www.dol.gov/owcp/energy/regs/compliance/weeklystats.htm See Attachment B Project Description Item 1.

2. Please clarify the timeframe of the new beneficiaries.

Response: The EEOICPA Website does not indicate the time frame for the information listed on the EEOICPA Website. In addition, the Applicant contacted a representative from the DOL/EEOICPA district office and the supervisor in that office was unable to give the time frame for the statistics. The information on the Website is not stored in a way that is available to the public so it is not possible to determine the number of new patients by comparison to the information on a specific prior dates . However, according to the updated information on the Website as of June 14, 2015, there were 14,242 approved cases in Tennessee which is an increase of 27 new approved cases in three weeks. If that trend continued, there would be a 468 increase in approved cases approved in Tennessee each year.

3. What percentage of the 14,215 new EEOICPA beneficiaries requires home health services?

Response: The Applicant has no way of knowing how many EEOICPA beneficiaries qualify for home health care, however, the disease and conditions that qualify for EEOICPA coverage are of the type that are progressive, debilitating and require long term care which typically require home health care. However, according to the DOL's Medical Provider Update, Home health care is by far the biggest medical expense category payable by EEOICPA. See Attachment B Project Description Item I.

4. What is the trend of EEOICPA eligible volume in Tennessee over the past 10 years? Is this population truly growing?

Response: The exact volume of increase for Tennessee in the past ten years is not available; however, according to graphs prepared by the EEOICPA Statistics, the total EEOICPA compensation paid from June 2001 to December 2014 for the Y-12 National Security Complex, the Oakridge National Laboratory and the Oak Ridge Gaseous Diffusion Plant increased dramatically. Each graph evidences a significant increase of EEOICPA eligible volume in Tennessee since the initiation of the EEOCIPA. Please

note that although there are 12 DOE worksites in Tennessee, the EEOICP only provided cumulative compensation statistics for the three aforementioned worksites and there are eight DOE worksites in the project's Service Area.
See Attachment B, Project Description, Item I.

5. Please clarify if workers are better protected from radiation exposure than they were in the past.

Response: The Applicant is not qualified to know whether or not workers are better protected from radiation exposure than they were in the past; however, EEOICPA claims are not limited to diseases that result from radiation exposure but from working with other toxic substances such as chemicals, solvents, acids and metals. There are hundreds of chemicals that people are still being exposed to today that cause a wide array of illness. There are so many different chemical exposures that a data base now exist with department of labor showing all exposures at all sites. This is not limited to just radiation exposure or people who worked on the atomic bomb.

Please clarify if a Registered Nurse has been identified to act as the Director of Nursing. If so, please provide an overview of their experience in providing home health care.

Response: The Applicant has two potential candidates for the Director of Nursing position. Both candidates have experience in case management in home health care.

Please clarify which private insurers reimburse for EEOICPA care. What percentage of the applicant's EEOICPA patients would be enrolled in private insurance in Year One and Year Two of the proposed project?

Response: EEOICPA is the payment program through the Department of Labor. Since EEOCIPA fully pays for the EEIOCPA beneficiaries' care, most EEOCIPA patients are not enrolled in private insurance and would not be in Year One or Year Two of the proposed project.

Please provide a description of the duties, functions and tasks which the applicant intends to perform as part of "home health nursing services".

Response: The Applicant will provide all the personal support services that it currently provides but will also provide skilled nursing care. These services will be provided for extended hours in the home instead of the shorter intermittent visits that are provided by typical home health agencies. Home health agencies

typically provide intermittent visits limited to one skill at each visit such as wound care or medication management. Patriot will provide care for the patient's entire well-being and will not be limited to performing only one skill. The main focus of the care will be their covered EEOICPA conditions. The patient will be assessed by the RN case manager weekly and changes will be made constantly to the patient's plan of care as their needs change and their disease progresses.

Please provide a brief description of the owner's expertise in starting and managing a home health agency. Please include the volume of patients served in the response.

Response: The owner of the Applicant is Caleb Mullins. He has been managing a personal support service agency for the past year along with his wife, Megan Mullins. Mrs. Mullins previously worked as a manager for a home health agency and has four years of experience in managing home health services to beneficiaries of EEOICPA and acts as the Director of Patriot.

It is noted the applicant does not intend to provide intermittent episodic care. However, on page 12 the applicant states simple weekly visits will occur. Please clarify.

Response: Not all patients will require 12 or 24 hour care, however, the Applicant's potential patient will require a longer or more frequent visit than provided by the typical home health agency. EEOICPA patients are usually suffering from a progressive or long term condition and will require care for the remainder of their life rather than for an episode of weeks or months.

What is the age range of your current EEOICPA personal support services clients being served?

Response: The Applicant's current patients' ages range from 40 to 91 years old.

Please provide documentation that homemaker and personal support services are defined in 42 CFR Section 440.80.

Response: 42 CFR Section 440.80 defines private duty services in part as follows:

§ 440.80 Private duty nursing services.
Private duty nursing services means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

This definition of private duty does not include personal support services or homemaker services. The Applicant seeks a CON to provide home health

services that include both private duty services and personal support / homemaker services.

It is noted the applicant is an authorized provider of home health services under EEOICPA. Please clarify what home service is currently authorized. In addition, has the applicant ever provided home health services to patients other than personal care services?

Response: The Applicant is currently licensed to provide personal support services in Tennessee and only provides personal support services. Unlike the state of Tennessee, EEOICPA does not distinguish between homemaker/ personal support services and other home health agency services when it approves a provider to be part of the program. Both personal support services and home health care are categorized as home health by the EEOICPA. The Applicant seeks to become a licensed home health agency in order to be able to provide home health services in addition to personal support services to EEIOICPA in the Service Area.

It is noted the applicant wants to include homemaker and personal support services as part of the establishment of a home health agency. Please respond to the following:

1. Please clarify that homemaker and personal support services are already being provided by the applicant. If so, would the applicant bill those services under the home health license or the personal care services license?

   Response: The Applicant currently provides homemaker and personal support services under its personal support services license. EEOICPA categorizes homemaker with personal care serves. If the Applicant is approved to become a Tennessee home health agency, the Applicant would discontinue providing care as a personal support services agency and would provide those services as part of its home health services.

2. Is the reimbursement for homemaker and personal care services the same under both licenses? Please clarify.

   Response: Yes. Homemaker services are the same as personal care services in the EEOICPA program. EEOICPA will not change its reimbursement rates for these services as a result of the Applicant becoming a Tennessee licensed home health agency.

It is noted the applicant holds a personal support services license from the State of Tennessee Department of Mental Health and Substance Abuse Services. Please provide an overview of the services provided, number and types of staff, counties covered, and number of patients. Please clarify why the applicant is not also seeking to provide home health services in conjunction with personal support services to this population.

Response: The Applicant is seeking to provide home health services to the population it now serves. One of the considerations in seeking to obtain a CON to provide home health services is to provide home health care as well as the personal support services to its current patients. The Applicant provides services in Roane, Meigs, Anderson and Knox. The Applicant currently contracts with or employs the following staff: 1 RN, 2 Office Employees, 14 Personal Care Attendants/Homemaker Aides (These fall under the same category with DOL) and 2 CNA's. Patriot's current client's receive anywhere between 35 hours -168 hours each per week of services. They all receive 8 hours per month (2 hours per week of case management). An overview of the services which Patriot currently provides is at Attachment B Project Description Item 1.

On page 21 the applicant states low cost equipment such as blood pressure cuffs will be purchased by the applicant. With this in mind, please discuss the typical patient the applicant will provide care to.

Response: The typical EEOICPA patient suffers from respiratory conditions, cancer, and other consequential illnesses caused by their main covered condition. These conditions are related to exposure to asbestosis, beryllium, and in our older clients radiation exposure. These are just a few of the work place related exposures. The typical patient hears about a home health agency through word of mouth since EEOICPA is not widely promoted by Department of Labor, and in the Applicants experience, is often unknown to physicians, and the potential clients. The Applicant has several physicians that currently work well and willingly with the Applicant.

Clients typically start out with personal care attendant services and as their disease progresses, they require more skilled care. Patriot would provide focused care for their DOL covered condition while meeting all of their skilled needs. The skilled nurse will provide assistance with activities of daily living, administer medications, educate the patient about their disease and disease progression, provide transportation to physicians appointments, provided communication to the physician's office regarding all aspects of their care, address safety concerns in the home, provide respite care, provide vital sign monitoring, and provide other skilled care as needed (ex. Wound care). EEOICPA pays for patients to have more hours of care in the home and therefore, patients do not have to move to a long term care skilled nursing facility. Home care is better for the patient's health and quality of life and is a more economical alternative for EEOICPA, the patient, and their families.

Please identify the other home health agencies in the service area that provides both homemaker and private duty services to EEOICPA patients.

Response: Based on the 2014 Joint Annual Reports, there was only one other home health agency that provided both homemaker and private duty services to EEOICPA patients.

Please complete the following chart:

Home Health Agency/Personal Care Agency	Provides Personal Care Services to EEOICPA Patients	Contracted with TDMHSAS to provide Personal Care Services	Provides Intermittent Home Health Care to EEOICPA Patients	Provides Skilled Nursing Care to Intermittent EEOICPA Home Health Care Patients.	Counties Served				
					Anderson	Knox	Meigs	Morgan	Roane
Home Health Agency									
Amedysis Home Health Care				X	X	X		X	X
Blount Memorial Home Services				X	X	X			
Camelia Home Health	x			X	X	X	X	X	X
Clinch River Home Health				X	X	X		X	X
Covenant Homecare and Hospice				X	X	X		X	X
Professional Case management of Tennessee					X	X	X	X	X
The Home Option of Harden Health Care	x		X	X	X	X			X
Sunbelt Homecare				X	X	X		X	X
Tennova Home Health				X	X	X		X	X
UT Medical Center Home Care Services				X	X	X		X	X

Gentiva Health Services				X	X	X	X		X
Personal Care Agency									
ABC Inc.	x	x				x			
Brightstar Care	x	x				x			
Daybreak Personal Services	X	x			x				
East TN Personal Care Service	X	x				x			
Home Helpers of East TN	x	x				x			
Hope 4 Tomorrow LLC	x	x			x				
Rescare Homecare-Knoxville	x	x				x			

2. Section C, Need, Item 1.a. (Project Specific Criteria-Home Health Services) (1-4)

Please complete the following chart for home health agencies in the 5 county service area that provides care to EEOICPA patients.

Existing Licensed HHAS & Their Utilization serving the 5-County Declared Service Area

Agency (license #)	Total Counties authorized in license (# counties in PSA)	2012 JAR Total EEOICPA patients served	2013 JAR Total EEOICPA patients served	2014 JAR Total EEIOCPA patients served	% Change from 2012-2014
Total –					

Response: This information is not available to the Applicant. The Joint Annual Reports do not account for EEOICPA patients served. The EEOICPA does not report publically how many patients any qualified provider serves.

Based on the home health need formula, please discuss why the applicant feels there is a need for an additional home health service agency at this time.

Response: Based solely on the need formula, no additional service is needed in the Service Area. However, the home health need formula is based on general

information reported by the licensed home health agencies and population statics. The home health need formula does not distinguish between the types of services or the payment source in determining the need for an additional home health service agency. Although this formula is important in ensuring a stable health care system, it does not adequately reflect the need for the specific type of services that the Applicant proposes to provide to a specific population in a specific geographic area. Based on the 2014 JARs, there is only one other agency in the Service Area providing both private duty and homemaker type services to EEOICPA beneficiaries and only 3 providing private duty nursing to EEOICPA beneficiaries.

3. Section C. Need, Item 1 (Specific Criteria: Home Health Services, Item 5 – Documentation of Referral Sources)

Please address the following home health criterion:

Letters:

5 (a) The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

Response: A letter from Dr. Foote is attached. See Attachment C Need 5.

5 (c) The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

Response: A letter from Dr. Foote and two letters from patients, including the concurrence of Summit Medical Group of Oak Ridge, Tn, are attached.
See Attachment C Need 5.

5 (b) The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

Response: The Applicant would be referred patients who are EEOICPA beneficiaries. Unlike, patients receiving home health care reimbursed by other government programs, EEOICPA beneficiaries are not typically referred by their physician. Once a beneficiary is authorized to receive EEOICPA benefits they contact a qualified provider for the services which they are authorized to receive. Patriot would work with the physician who provides services to the EEOICPA beneficiary.

5 (d) The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

Response: The Applicant would provide "private duty" type care together with personal care and homemaker services. The Applicant believes that only one other EEOICPA home health provider is providing this combination of services as an option for its patients.

4. Section C. Need Item 1 (Specific Criteria: Home Health Services) - Item 6A and 6B

Please address the following home health criterion:

A) The average cost per visit by service category shall be listed.

Response: EEOICPA does not reimburse the cost of care based on a per visit basis but on an hourly basis. Since the number of hours dedicated to each patient is different depending on their needs there is no way to calculate the average cost per visit. If a patient receives more nursing care then the cost per visit would be higher than for a patient receiving more hours of homemaker services.

B) The average cost per patient based upon the projected number of visits per patient shall be listed.

Response: The typical EEOICPA beneficiary receives care for the remainder of their life so it is impossible to project the number of visits per patient. Therefore, impossible to project the average costs per patient. However, since all of the care is paid for by EEOICPA, there would be no cost to any other private or government insurance program.

5. Section C, Need, Item 6

Please provide the details regarding the methodology used to project 30 patients during the first year of operation and 60 patients during the second year of operation. The methodology must include detailed calculations or documentation from referral sources.

Response: The typical EEOCIPA beneficiary is not referred from another provider but relies on the list of EEOICPA qualified agencies to seek home health care. Dr. Clary Foote has stated that he would refer his EEOICPA patients to the Applicant. The Applicant's projection of 30 patients in the first year and 60 patients in the second year is based on its experience with the growth of its personal support services to EEOICPA beneficiaries and the request for services

from EEOICPA services that it has received. Patriot was established in 2014 and has grown to 15 patients in the first year. It believes that the need for personal support services combined with nursing care would result in the number of patients doubling each year. Unlike the typical home health patient, EEOICPA patients almost always continue to need the home health services for the remainder of their life so the number of patients does not decrease unless there is death; however the number of EEOICPA beneficiaries is increasing weekly.

Please complete the following chart for Year One of the proposed project:

Patient	Currently receiving EEOICPA Personal Care Services from Patriot	Currently receiving EEOICPA Home Health Services	Currently a Personal Care Patient of Patriot currently meets medical criteria for EEOICPA home health services but not receiving them	Past/or Future referral from Dr. Clary Foote (Please Specify)*	Patient County				
					Anderson	Knox	Meigs	Morgan	Roane
#1	x	x			x				
#2	x	x				x			
#3	x	x					x		
#4	x		x	Past					x
#5	x		x						x
#6	x		x		x				
#7	x		x		x				
#8	x				x				
#9	x				x				
#10	x				x				
#11	x						x		
#12	x			Past					x
#13	x			Past					x
#14	x								x
#15	x								x
#16	In Process			Future					
#17	In Process			Self- referred					
#18	In Process			Self -referred					
#19				Self -referred					
#20				Self -referred					
#21				Self -referred					
#22				Self -referred					
#23				Self -referred					

#24				Self -referred					
#25				Self -referred					
#26				Self -referred					
#27				Self -referred					
#28				Self -referred					
#29				Self -referred					
#30				Self -referred					
Total									

6. Section C. Economic Feasibility Item 1 (Project Cost Chart)

There appears to be a typo under the Legal, Administrative, and Consultant Line. Please revise and submit a replacement page.

Response: A revised Project Cost Chart is attached as Attachment C Economic Feasibility Item 1.

The one year leased space cost of $6,000 is noted in the Project Cost Chart. However, please provide the fair market value and resubmit.

Response: The Applicant believes that the fair market value of the lease space is approximately $10,500. The lease is a month to month lease at a rental of $500 per month. The cost of the lease over the term is $500. Please see the revised Project Cost Chart attached as Attachment C Economic Feasibility.

Where has office furniture, fax machines, computers, medical billing, etc. been accounted for in the Project Costs Chart?

Response: Patriot has adequate office furniture, fax machines, computers, medical billing and would not have to purchase a these items.

7. Section C. Economic Feasibility Item 2 (Funding)

The bank statement from SunTrust Bank for Camm Care, LLC with an ending balance of $39,319.41 as of May 31, 2015 is noted. However, it appears this account is dedicated to a separate line of business other than what the applicant is seeking in this Certificate of Need application. Please clarify how this account will support the current personal care services line of business, in addition to launching a home health business that involves the employment of 61 FTEs and providing care to 30 patients in Year One.

Response: The Suntrust Bank account for Camm Care, LLC is the bank account for the personal support services agency and the reserves will support a steady growth in patients and services. If the Applicant is successful in being granted a CON to provide, home health services, the Applicant will not continue to operate the personal support services business as a separate business from its home health agency but will expand its operations to include the additional nursing services that a home health agency can provide. The reserves would be available to grow its current business as a home health agency.

The letter from the applicant attesting to the availability of cash to fund the proposed project is noted. However, please provide a letter from a bank that attests to the availability of cash reserves to fund the project.

Response: A letter from SunTrust Bank is attached at Attachment C Economic Feasibility Item 2.

Please clarify why the applicant does not currently have the cash reserves to pay for legal fees associated with the project and must rely on future anticipated cash reserves?

Response: The Applicant has adequate cash reserves to pay legal fees. The only remaining legal fees are $10,000 and there are more than adequate reserves to pay all remaining legal fees.

The funding letter from Caleb Mullins of Patriot Homecare that states a majority of the project costs have already been paid is noted. However, on page 21 of the application it states the filing fee of $3,000 which represents 7.8% of the project costs has been paid. Please clarify.

Response: The only remaining unpaid project costs are $10,000 for legal fees and license fee of $1080.

8. Section C. Economic Feasibility Item 4 (Projected Data Chart)

Please clarify the reason salaries and wages expense increases from $2,042,728 in Year One to $3,889,456 in Year Two, while FTE employees are projected to be 61 in both Year One and Year Two.

Response: Please see the revised staffing chart at Attachment C Contribution to the Orderly Development of Health Care Item 3.

Please complete the following chart for Other Expenses:

Caleb and Megan revise the chart below as needed.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year One	Year Two
1. Utilities, Telephone	$ 3,000	$ 3,000
2. Insurance	2,000	2,000
3. Professional fees	2,500	2,500
4. Contingency fund.	1,500	1,500
5.		
6.		
7.		
Total Other Expenses	**$10,000**	**$10,000**

9. Section C, Economic Feasibility, Item 8

If there is an unexpected major delay in the payment of claims in Year One, how will the applicant pay employees and sustain services to existing home health patients?

Response: Unexpected delay would result in a hardship and the Applicant would have to draw on any reserves. However, EEOICPA has a long history of timely quarterly payments and it is unlikely that there would be any delay in payment of claims.

10. Section C, Economic Feasibility, Item 10

Please provide a copy of the latest balance sheet and income statement for the applicant as well as the most recent **audited** financial statements with accompanying notes, if available.

Response: The Applicant's profit and loss statement for March 2015 and the balance sheet and profit and loss statement for May 2015 are attached at Attachment C, Economic Feasibility Item 10. The Applicant does not have audited financial statements but has provided its year end bank statement and Letter from SunTrust at Attachment C Economic Feasibility Item 10.

11. Section C, Orderly Development, Item 3

The employment chart in Attachment C, Orderly Development 3 is noted. However, please provide a source that documented the prevailing wage patterns in the service area.

Response: The source that documented the prevailing wage patterns in the service area is the Tennessee Department of Labor and Workforce Development's 2014 Occupational Wage Report found at http://www.tn.gov/labor-wfd/wages/2014/TOC000.htm

Please clarify the reason 30 Personal Care Attendants were included in the staffing chart.

Response: Some of the care provided by the Applicant will be provided by Personal Care Attendants. Personal Care Attendants provide assistance with daily living, such as bathing, dressing etc. In addition, they may also provide homemaker services.

Please let me know if you have any further questions for the Applicant in order to deem this Application complete.

Very truly yours,

Anne Sumpter Arney

ASA/kh
Enclosures

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Cumm Care LLC dba Patriot Homecare

I, Anne Sumpter Arney, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Anne Sumpter Arney
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 23rd day of June, 2015 witness my hand at office in the County of Davidson, State of Tennessee.

Kristie Putman
NOTARY PUBLIC

My commission expires May 3, 2016

KRISTIE PUTMAN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02

United States Department of Labor
Office of Workers' Compensation Programs
Office of Workers' Compensation Programs (OWCP)

EEOICP Program Statistics

Last year, the DEEOIC deployed a new case management system for use by our claims staff. The new system is constructed differently than the previous system, and we determined that it was appropriate to re-examine our statistics and how they are displayed on the web site. For the past several months, we have been working on reconstructing the site and the statistics. Therefore, viewers may notice some differences in the web statistics.

The separate category for the non-covered applications has been removed and those counts are now included in the Final Decision counts. Although the number of posted denials appears to increase, there is not an increase in total numbers. Denials are being shown under a single category instead of being split into two separate counts.

In the past, on our state-by-state pages, medical bill payments were attributed to each state in which any claimant (including multiple survivors) on the case resided, resulting in an overstatement of the amount of medical bill payments in a given state. Medical bill payments are now being attributed to the state in which the employee resides. Although the National page total was not affected by this change, the current state medical totals will show a reduction from previously-reported amounts.

A list of definitions for the terms used on the EEOICP Program Statistics web pages is available here.

Highlights

- View Part B Statistics
- View Part E Statistics
- View Part B NIOSH and SEC Statistics

TENNESSEE

Data as of 05/25/2015
Statistical data updated weekly on Mondays

Combined Part B and E Summary

		CLAIMS	CASES
Applications Filed		39,041	27,625*
Total Compensation Paid	Payments	14,728	11,753
	Total Dollars		$1,525,362,890
Total Medical Bills Paid	Total Dollars		$436,539,720
Total Compensation + Medical Bills Paid			$1,961,902,610

* The above numbers of applications filed represent 15,721 unique individual workers.

Part B

		CLAIMS	CASES
Applications Filed		19,376	13,301
Final Decisions			
	Approved	9,915	7,169
	Denied	7,308	5,224
	Total	17,223	12,393
Compensation Paid			
	Payments	8,974	6,502
	Total Dollars		$910,818,700

Part E

		CLAIMS	CASES
Applications Filed		19,665	14,324
Final Decisions			
	Approved	8,269	7,046
	Denied	9,284	6,023
	Total	17,553	13,069
Compensation Paid			
	Payments	5,754	5,251
	Total Dollars		$614,544,190

SUPPLEMENTAL

Anne Sumpter Arney

From: United States Department of Labor <subscriptions@subscriptions.dol.gov>
Sent: Friday, June 19, 2015 1:54 PM
To: Anne Sumpter Arney
Subject: DEEOIC Medical Provider Updates

UNITED STATES DEPARTMENT OF LABOR

Good jobs for everyone.

DEEOIC Medical Provider Update

Subscribe to this newsletter

June 19, 2015

U.S. Department of Labor/Office of Workers' Compensation Programs/Division of Energy Employees Occupational Illness Compensation, 200 Constitution Ave., NW, Washington, DC 20210

Web: www.dol.gov/owcp/energy/ **Email:** Deeoic-public@dol.gov **Phone:** 1-866-888-3322

Countdown to ICD-10

DEEOIC is currently working to transition our medical bill processing system from ICD-9 to ICD-10. The implementation to ICD-10 is a government-wide initiative scheduled for implementation October 1, 2015. ICD-10 represents a significant expansion of the diagnosis and disease coding for medical bill processing. DEEOIC has developed a simple question and answer document on the subject.

- View additional information about the transition
- View the Frequently Asked Questions for Medical Providers (PDF)

Home Health Care Statistics

Do you know what one of the largest expense categories is for medical bill payment under the DEEOIC? The answer is Home Health Care. It is by far the biggest medical expense category payable by the program. As of March 31, 2015, DEEOIC has paid more than $1.2 billon to ensure that employees with accepted work-related illnesses receive medically appropriate home health care services. Our Denver district office processes the greatest number of home health care claims.

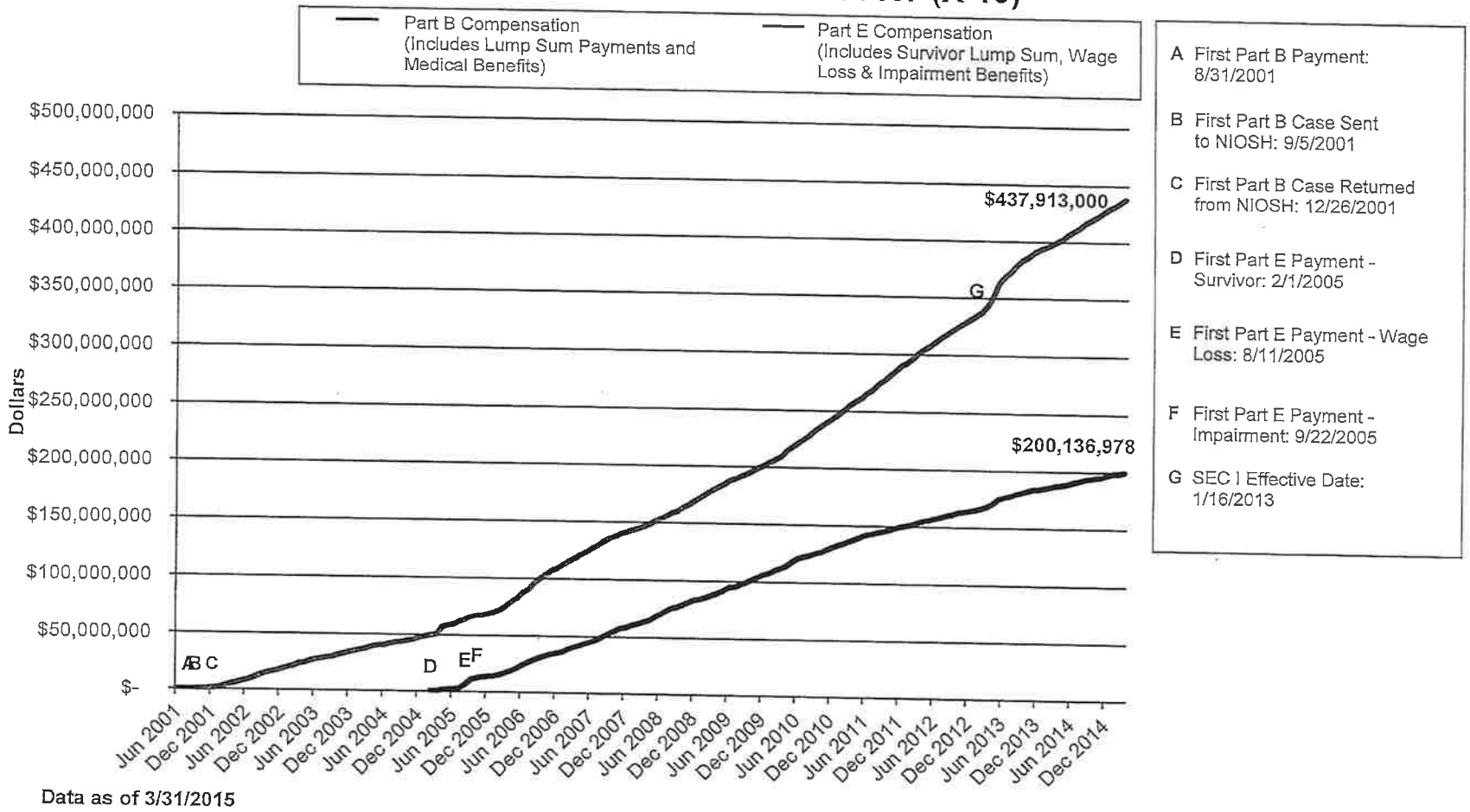
- View a distribution of home health care expenses by district office (PDF)

Insider Tip

DEEOIC pays prescription medications based on Federal Drug Administration (FDA) guidance on the designated use(s) of a drug to treat specific disease or illness. Medication prescribed to treat a DEEOIC accepted illness that is "off label" or not recognized by the FDA as a treatment of the condition requires special processing. When a physician has prescribed an "off label" medication to treat a DEEOIC accepted medical condition, the patient will be asked to supply the following information to receive consideration for coverage:

a. Medication Name
b. 11 digit National Drug Code

Cumulative EEOICPA Compensation Paid - OAK RIDGE NATIONAL LABORATORY (X-10)



A First Part B Payment: 8/31/2001

B First Part B Case Sent to NIOSH: 9/5/2001

C First Part B Case Returned from NIOSH: 12/26/2001

D First Part E Payment - Survivor: 2/1/2005

E First Part E Payment - Wage Loss: 8/11/2005

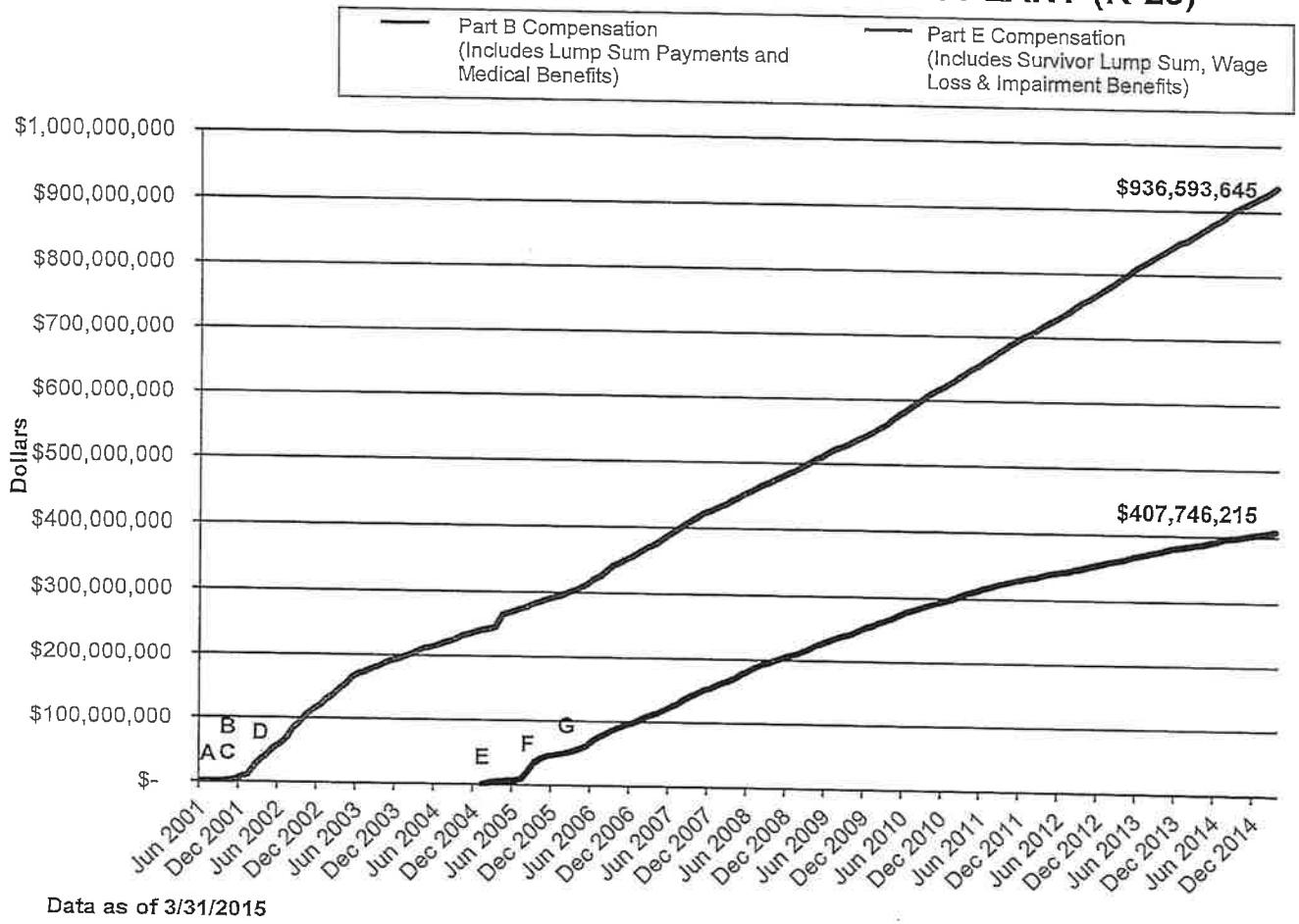
F First Part E Payment - Impairment: 9/22/2005

G SEC I Effective Date: 1/16/2013

Data as of 3/31/2015

SUPPLEMENTAL

Cumulative EEOICPA Compensation Paid - OAK RIDGE GASEOUS DIFFUSION PLANT (K-25)



A SEC I Effective Date: 7/31/2001

B First Part B Payment: 10/2/2001

C First Part B Case Sent to NIOSH: 10/15/2001

D First Part B Case Returned from NIOSH: 3/27/2002

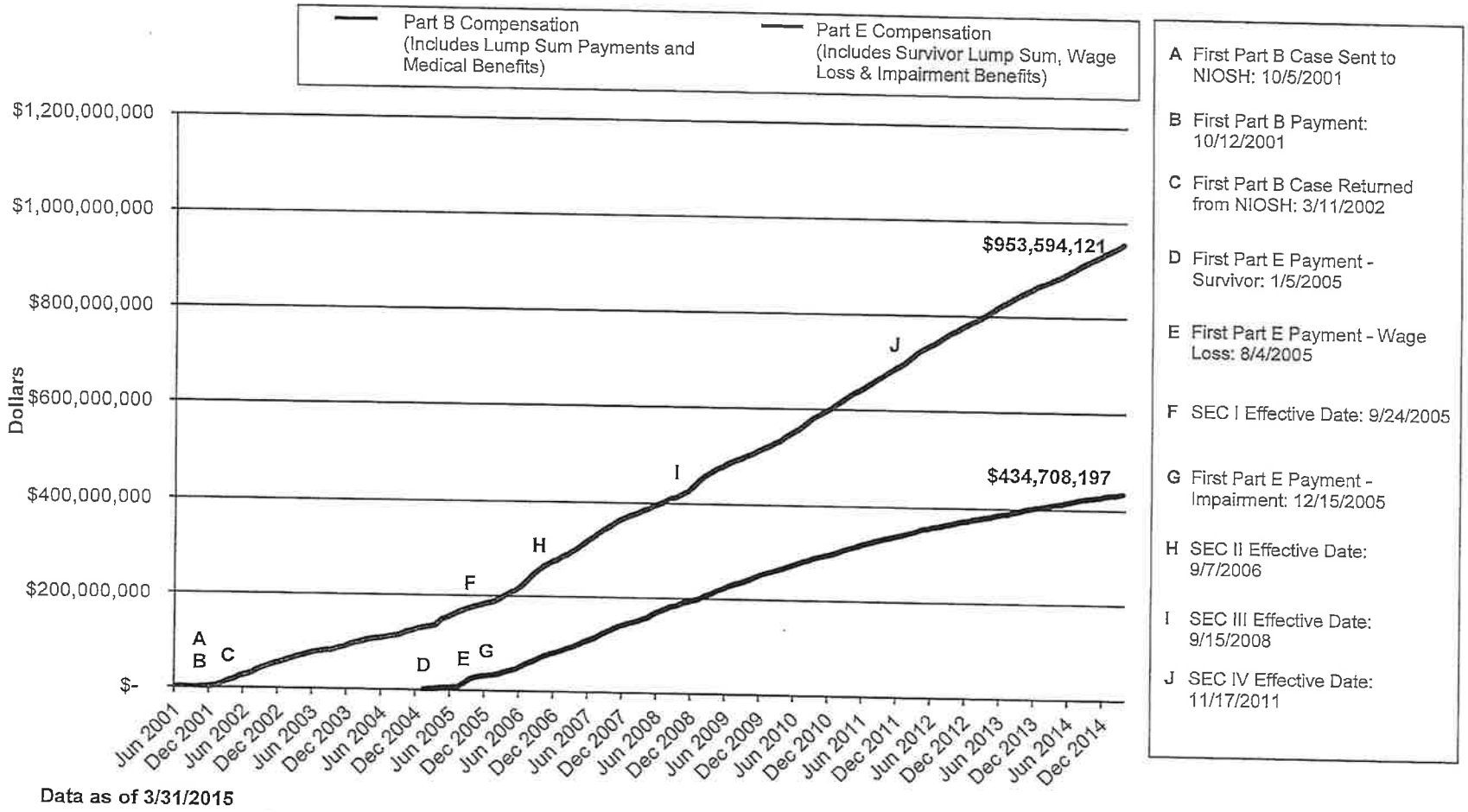
E First Part E Payment - Survivor: 1/5/2005

F First Part E Payment - Wage Loss: 8/4/2005

G First Part E Payment - Impairment: 2/2/2006

Data as of 3/31/2015

Cumulative EEOICPA Compensation Paid - Y-12 PLANT



Data as of 3/31/2015

SUPPLEMENTAL

Attachment B Project Description Item 1

Overview of Services

- Perform housekeeping duties, such as cooking, cleaning, washing clothes or dishes, or running errands
- Care for individuals by providing companionship, personal care, or help in adjusting to life changes
- Provide assistance during all activities of daily living
- Provide personal care or ambulation assistance during personal care
- Prepare and maintain records of client progress and services performed, reporting changes in client condition to RN supervisor
- Plan, shop for, or prepare nutritious meals based on client's plan of care
- Participate in case reviews, consulting with the team caring for the client to evaluate the client's need for continued services
- Instruct or advise clients on issues such as household cleanliness, hygiene, or nutrition
- Provide clients with communication assistance with physician offices
- Transport clients as needed to physician's offices in their personal vehicle
- Train family members to provide care
- Assist client with vital sign monitoring
- RN case manager completes an initial assessment of client and family to determining home care needs, regularly re-evaluates patient's home care needs, initiates the plan of care and makes necessary revisions as client's status and needs change, develops a care plan which establishes goals, based on covered diagnosis and incorporates preventive and rehabilitative actions, counsels the client and family in meeting home care needs, provides instructions to client as appropriate per assessment and plan, identifies discharge planning needs as part of the care plan development and implements prior to discharge of the client, prepares clinical notes and updates the primary physician when necessary, communicates with the physician regarding the client's needs and reports any changes in the client's condition,obtains/receives physicians orders as required, communicates with appropriate persons to coordinate care plan and ensures that communication for equipment and other necessary items and services are available and communicated to the office.

ATTACHMENT C NEED 5

Dr. Clary Foote, M.D., P.C.
190 North Roane Street
Harriman, Tn 37748
Ph: 865-882-2800
Fax: 865-882-3512

April 13, 2015

Clary Foote, MD
190 N Roane Street
Harriman, TN 37748
P: (865)882-2800

Tennessee Health Services Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

To Whom it May Concern:

I am writing this letter on behalf of CAMM Care LLC dba Patriot Homecare. Patriot Homecare currently provides personal care services to my patients. I will continue to be a referral source to them in support of them pursing their Certificate of Need. This will allow my patients to receive all of their care from one source and will allow us to work together to provide a more focused plan of care without the hassle and inconvenience of having multiple companies involved in their care. I believe this will also improve on the quality of care that my patients receive.

This is a much needed service in our area and I believe CAMM Care LLC dba Patriot Homecare will continue to provide quality, compassionate care to my patients. If I can be of any more assistance, please feel free to contact our office.

Sincerely,

Clary Foote, MD

ATTACHMENT C NEED 5

SUPPLEMENTAL

[redacted]

June 4, 2015

State of Tennessee
Health Services & Development Agency
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

Dear Gentlemen and Ladies:

I have been accepted with several illnesses with DOL, EEOICPA since 2007. I was approved to receive the benefits of skill nursing (8 hours a day, 5 days a week) and home care services (24 hours a day, 7 days a week) July 2014. I required the services long before I received them. It was a matter of dealing with strangers in my home daily.

Since July 2014, I have had three nurses to come to my home to provide me with RN services 8 hours a day, five days a week; this working with two separate providers. The first provider worked for herself and it was difficult for her to work without oversight and had no one to replace her the times she was not able to show up. The next two proved to be untrustworthy and unhealthy to be in my home. These providers did not care about my well fare only that they were able to bill off me. Currently, I only receive RN case management with my personal care services through Patriot; which means, I am presently without nursing care.

I am hoping and praying that Patriot will be awarded the opportunity to provide Nursing as well as the home makers; which they are doing an outstanding job with integrity and the personal care they give each patient. This year has been difficult having to deal with two different providers. I know from my personal experience that it would be easier on the patient if services were under one provider that cares and is serious about taking care of the patient. I keep my physicians informed and they are concern about certain providers misusing patients in this program. My physicians work willingly with Patriot on my behalf without disappointment.

My phone is constantly ringing where word is out that I have accepted conditions with DOL; different providers call who has partnered with the union or lawyers to grab up approved patients for their own benefit. I know I can trust Patriot to care for me. If you should have any questions, feel free to contact me any time on my cell which is [redacted] or my home number which is [redacted].

Respectfully,

[redacted]

cc: Dr. Bridgeman

I concur with the above.
Pamela L. Bridgeman, MD

Summit Medical Group of Oak Ridge
901 Oak Ridge Turnpike
Oak Ridge, TN 37830

ATTACHMENT C NEED 5

June 4, 2015

I currently receive personal care services through Patriot Homecare. I am in need of nursing services but have been too leery of trying to obtain them through another company because of other family member's experiences. I hope that Patriot can become licensed and provided my nursing services. They have been very caring and helpful with everything that I have needed. They always go above and beyond to make sure all of my needs are met and make me feel like I am their only patient. They are also very knowledgeable about Department of Labor which has helped me a great deal. I hope that this is a service they can provide as I know that I am in need now but do not want to deal with another company.

Sincerely,

[redacted]

PROJECT COSTS CHART

SUPPLEMENTAL

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$25,000
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000)	1,500
	9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	10,500
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)_____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other- License Fee	1,080
D.	Estimated Project Cost (A+B+C)		38,080
E.	CON Filing Fee		3,000
F.	Total Estimated Project Cost (D+E)		
		TOTAL	$41,080

SUPPLEMENTAL

SUNTRUST

To whom it may concern,

As of December 31, 2014 the Business Checking Account ending in 4074 of Camm Care LLC had an average balance of $48,438.24.

As of June 18, 2015 the Business Checking Account ending in 4074 of Camm Car LLC had a balance of $34,810.40.

Matthew Marshall

Financial Services Rep

Oak Ridge In-Store

Office: 865-294-0156

Email: Matthew.R.Marshall@suntrust.com

ATTACHMENT C CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE SUPPLEMENTAL
ITEM 3

Position	No. of Full Time Equivalent Employees	1st Year	2nd Year	Applicant's Planned Salary/Wage Range	Prevailing Wage for this type of Employee
Administrator	1	1	1	$40,000/year	$68,343/year*
Director of Nursing	1	1	1	$80,000/year	$51,631/year
Contracted RNs	2	2	2	$30/hour	$24/hour
Staff LPNs	15	15	30	$26/hour	$17/ hour
Certified Nursing Assistant	10	10	20	$11/hour	$10/hour
Personal Care Attendant	30	30	60	$10/hour	$10/hour
Marketing Director	1	1	1	$50,000/year	$77,768/year
Receptionist	1	1	1	$26,000/year	$21,985/year
Total	61	61	116	---	---

SUPPLEMENTAL

8:28 AM
06/18/15
Cash Basis

CAMM CARE LLC
Profit & Loss
January through March 2015

	Jan - Mar 15
Ordinary Income/Expense	
Income	
Gross Income	198,051.29
Total Income	198,051.29
Gross Profit	198,051.29
Expense	
OPERATING EXPENSES	
Advertising and Promotion	1,679.44
Bank Service Charges	8.90
Computer and Internet Expenses	474.80
Contract Labor	92,544.00
Employee Wages	6,144.92
Meals and Entertainment	141.48
Mileage Expense	3,155.02
Misc Expenses	708.50
Office Supplies	2,090.49
Professional Fees	8,800.00
Rent Expense	1,000.00
Taxes and Licenses	20.00
Telephone Expense	1,435.95
Utilities	1,037.16
Total OPERATING EXPENSES	119,240.66
Total Expense	119,240.66
Net Ordinary Income	78,810.63
Net Income	78,810.63

8:14 AM
06/18/15
Cash Basis

CAMM CARE LLC
Profit & Loss
May 2015

	May 15
Ordinary Income/Expense	
Income	
Gross Income	90,843.76
Total Income	90,843.76
Gross Profit	90,843.76
Expense	
OPERATING EXPENSES	
Advertising and Promotion	150.00
Bank Service Charges	8.75
Computer and Internet Expenses	153.32
Contract Labor	49,225.00
Employee Wages	5,531.29
Insurance Expense	211.60
Meals and Entertainment	50.40
Mileage Expense	1,512.25
Mileage Reimbursement	586.50
Misc Expenses	940.69
Office Supplies	493.48
Professional Fees	250.00
Repairs and Maintenance	10.00
Telephone Expense	197.13
Utilities	130.66
Total OPERATING EXPENSES	59,451.07
Total Expense	59,451.07
Net Ordinary Income	31,392.69
Net Income	31,392.69

SUPPLEMENTAL

8:16 AM
06/18/15
Cash Basis

CAMM CARE LLC
Balance Sheet
As of May 31, 2015

	May 31, 15
ASSETS	
Current Assets	
Checking/Savings	
SUNTRUST BANK	39,451.49
Total Checking/Savings	39,451.49
Total Current Assets	39,451.49
Fixed Assets	
Furniture and Equipment	546.23
Total Fixed Assets	546.23
TOTAL ASSETS	39,997.72
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	1,877.60
Total Other Current Liabilities	1,877.60
Total Current Liabilities	1,877.60
Total Liabilities	1,877.60
Equity	38,120.12
TOTAL LIABILITIES & EQUITY	39,997.72

ATTACHMENT C ECONOMIC FEASIBILITY ITEM 10

SUPPLEMENTAL

CAMM CARE LLC
Reconciliation Summary
SUNTRUST BANK, Period Ending 05/31/2015

	May 31, 15
Beginning Balance	2,674.56
Cleared Transactions	
Checks and Payments - 109 items	-52,389.79
Deposits and Credits - 10 items	89,034.64
Total Cleared Transactions	36,644.85
Cleared Balance	39,319.41
Uncleared Transactions	
Checks and Payments - 6 items	-1,757.92
Deposits and Credits - 1 item	1,890.00
Total Uncleared Transactions	132.08
Register Balance as of 05/31/2015	39,451.49
New Transactions	
Checks and Payments - 7 items	-11,933.76
Total New Transactions	-11,933.76
Ending Balance	27,517.73

ATTACHMENT C ECONOMIC FEASIBILITY ITEM 10

SUPPLEMENTAL

SUNTRUST BANK
PO BOX 305183
NASHVILLE TN 37230-5183

36/E00/0175/0 /53
[redacted]4074
05/31/2015
0000

SUNTRUST

Account Statement

CAMM CARE LLC
514 DEVONIA ST
HARRIMAN TN 37748-2115

Questions? Please call
1-800-786-8787

HOW CAN WE HELP YOU MAKE THE RIGHT FINANCIAL CHOICES FOR TODAY AND TOMORROW?
WITH OUR VARIETY OF SOLUTIONS AND FINANCIAL GUIDANCE.
WE VALUE YOU AS A CLIENT AND WANT TO HELP YOU BANK THE WAY THAT FITS YOUR LIFE.
LEARN MORE AT SUNTRUST.COM.

Account Summary

Account Type	Account Number	Statement Period
PRIMARY BUSINESS CHECKING		05/01/2015 - 05/31/2015

Description	Amount	Description	Amount
Beginning Balance	$2,674.56	Average Balance	$18,370.32
Deposits/Credits	$89,034.64	Average Collected Balance	$17,980.16
Checks	$18,934.87	Number of Days in Statement Period	31
Withdrawals/Debits	$33,454.92		
Ending Balance	$39,319.41		

Deposits/ Credits

Date	Amount	Serial #		Date	Amount	Serial #	
05/05	735.00		DEPOSIT	05/14	1,155.00		DEPOSIT
05/08	735.00		DEPOSIT	05/26	3,000.00		DEPOSIT
05/13	5,080.88		DEPOSIT				
05/07	15,342.50		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500				
05/14	23,689.60		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500				
05/21	16,566.18		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500				
05/28	22,730.48		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500				

Deposits/Credits: 9 Total Items Deposited: 6

Checks

Check Number	Amount	Date Paid	Check Number	Amount	Date Paid	Check Number	Amount	Date Paid
298	100.00	05/26	327	924.00	05/15	340	924.00	05/21
*310	420.00	05/04	328	840.00	05/14	341	840.00	05/22
*316	500.00	05/06	329	924.00	05/15	342	400.00	05/21
317	164.20	05/07	330	400.00	05/14	343	924.00	05/22
318	401.75	05/08	331	401.75	05/11	344	401.75	05/19
319	560.39	05/05	332	560.39	05/11	345	560.38	05/20
320	420.00	05/13	333	150.00	05/26	*347	924.00	05/28
321	924.00	05/13	334	145.33	05/18	348	840.00	05/28
322	840.00	05/08	335	250.00	05/19	349	400.00	05/28
323	924.00	05/08	336	130.66	05/15	*351	401.75	05/26
324	59.15	05/26	337	80.88	05/13	352	560.39	05/26
325	211.60	05/20	338	586.50	05/13			
326	420.00	05/20	339	420.00	05/26			

Checks: 37 *Break in check sequence

Continued on next page

SUPPLEMENTAL

SUNTRUST BANK
PO BOX 305183
NASHVILLE TN 37230-5183

SUNTRUST

Account Statement

CAMM CARE LLC
514 DEVONIA ST
HARRIMAN TN 37748

Questions? Please call
1-800-786-8787

HOW CAN WE HELP YOU MAKE THE RIGHT FINANCIAL CHOICES FOR TODAY AND TOMORROW?
WITH OUR VARIETY OF SOLUTIONS AND FINANCAL GUIDANCE,
WE VALUE YOU AS A CLIENT AND WANT TO HELP YOU BANK THE WAY THAT FITS YOUR LIFE.
LEARN MORE AT SUNTRUST.COM.

Account Summary

Account Type	Account Number	Statement Period
PRIMARY BUSINESS CHECKING		12/01/2014 - 12/31/2014

Description	Amount	Description	Amount
Beginning Balance	$45,136.90	Average Balance	$48,535.98
Deposits/Credits	$62,305.76	Average Collected Balance	$48,438.24
Checks	$9,839.30	Number of Days in Statement Period	31
Withdrawals/Debits	$48,556.84		
Ending Balance	$49,046.52		

Deposits/Credits

Date	Amount	Serial #	
12/09	5,000.00		DEPOSIT
12/15	1,900.00		DEPOSIT
12/04	2,975.22		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500
12/11	18,188.88		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500
12/18	540.00		*ELECTRONIC/ACH CREDIT* INTUIT PAYROLL S QUICKBOOKS 465202800
12/18	16,709.24		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500
12/24	15,762.42		*ELECTRONIC/ACH CREDIT* EEOI TREAS 310 MISC PAY 618089000161500
12/22	630.00		DEPOSIT
12/29	600.00		DEPOSIT

Deposits/Credits: 9 Total Items Deposited: 5

Checks

Check Number	Amount	Date Paid	Check Number	Amount	Date Paid	Check Number	Amount	Date Paid
259	792.00	12/02	268	240.00	12/19	*1008	275.00	12/08
*262	360.00	12/05	269	924.00	12/23	*1012	500.00	12/08
263	924.00	12/09	270	350.00	12/19	1013	223.16	12/09
264	350.00	12/05	271	240.00	12/24	1014	392.30	12/10
265	240.00	12/12	272	924.00	12/29	1015	144.21	12/15
266	924.00	12/16	273	350.00	12/24	1016	271.63	12/11
267	350.00	12/12	*275	840.00	12/31	1017	225.00	12/11

Checks: 21 *Break in check sequence

Withdrawals/Debits

Date Paid	Amount	Serial #	Description
12/01	500.00		ONLINE BANKING TRANSFER TO 0175 1000110767984
12/01	57.77		*CHECK CARD PURCHASE* SHELL OIL 57546172602 KINGSTON TN TR DATE 11/27
12/02	4,000.00		ONLINE BANKING TRANSFER TO 0175 1000110767984
12/02	7.99		*RECURRING CHECK CARD PURCHASE* VISTAPR*VISTAPRINT.COM 866-6148002 CA TR DATE 11/30

Continued on next page

ORIGINAL
- #2
ORIGINAL

Patriot Homecare

CN1506-023

BONE MCALLESTER NORTON PLLC

SUPPLEMENTAL

Anne Sumpter Arney
615.238-6360 Phone
615.687.2764 Fax
asarney@bonelaw.com

June 29, 2015

Mr. Phillip Earhart
HSD Examiner
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
Nashville, Tennessee 37242

Re: Certificate of Need Application CN1506-023
CAMM Care LLC d/b/a Patriot Homecare

Dear Phillip:

The responses below are to reply to your letter dated June 25, 2015. This letter is being submitted in triplicate.

1. Section B, Project Description, Item I

It is noted the applicant currently provides personal care services in Roane, Meigs, Anderson, and Knox Counties. Please clarify why Morgan County is included in the proposed service area while the applicant does not currently have patients residing in that county.

Response: Morgan County is included in the Service Area because the Applicant is in the process of enrolling an EEOICPA patient in Morgan County for personal support services. In addition, the Applicant believes that there is a need for a home health agency dedicated to EEIOICPA beneficiaries in Morgan County. According to the 2014 Joint Annual Reports, no EEOICPA home health agency is providing homemaker services in Morgan County.

The chart that identifies the other home health agencies in the service area that provides both homemaker and private duty services to EEOICPA patients is noted. However, the chart supplemental 1 column five incorrectly included "intermittent" along with the skilled nursing category. Please clarify the data provided in the 1st supplemental response for column five applied only to EEOICPA skilled nursing patients.

Response: The Data provided in the first supplemental response in column five of the chart applied only to EEOICPA skilled nursing patients.

Nashville City Center, Suite 1600 - 511 Union Street - Nashville, Tennessee 37219
615.238.6300 (Phone) - 615.238.6301 (Fax)

2. Section C. Need, Item 1 (Specific Criteria: Home Health Services, Item 5 – Documentation of Referral Sources)

Letters:

5 (a) The applicant shall provide letters of intent from physicians and other referral sources pertaining to patient referral.

The letter of referral from Dr. Foote is noted. However, please provide a revised letter from Dr. Foote noting the number of referrals that will be made to the proposed agency in Year One and in Year Two of the proposed project. If possible, additional letters of intent from physicians and other referral sources would be helpful to justify Year One and Year Two patient volumes.

Response: The Applicant has attempted to contact Dr. Foote to provide a revised letter. Because of Dr. Foote's office hours, the Applicant is unable to obtain a revised letter from Dr. Foote within the required time to respond; however, Dr. Foote has stated in his letter at Attachment C Need 1, that he will refer patients to Patriot. One fifth of the Applicant's current patients for personal support services were referred by Dr. Foote. The Applicant believes that it is likely that Dr. Foote will, as he has stated, refer home health patients to Patriot. In addition, as the Applicant has previously stated, services under EEOICPA are not typically the result of a physician referral. Many physicians are unfamiliar with the program. Most referrals for home health services to EEOICPA beneficiaries are by word of mouth among patients and their family members. The Applicant intends to raise awareness of the availability of EEOICPA benefits through Patriot's marketing and make both physicians and potential beneficiaries aware of EEOICPA and Patriot's status as a qualified provider.

5 (c) The applicant shall provide letters from potential patients or providers in the proposed service area that state they have attempted to find appropriate home health services but have not been able to secure such services.

The letter from Dr. Foote is noted. However, the physician letter did not state attempts have been made to find appropriate home health services but they could not be secured. If possible, please revise and resubmit.

Response: Summit Medical Group of Oak Ridge has cosigned the letter from the patient at Attachment C Need, in which the patient states that they have been unable to find adequate home health services. Summit Medical Group of Oak Ridge has concurred with the statement that the patient has been unable to find adequate home health services.

Other

5 (b) The applicant shall provide information indicating the types of cases physicians would refer to the proposed home health agency and the projected number of cases by service category to be provided in the initial year of operation.

On page 7 of the supplemental response the applicant states the typical patient may suffer from respiratory conditions, cancer, or other consequential illness. Please indicate the types of cases and number of cases by service category in Year One.

Response: The types of cases will depend on the services needed by the patient. The typical EEOICPA patient suffers from serious respiratory illness and in most cases require continuous monitoring of their respiratory status in order to identify and treat any changes that can become emergent. In addition, as a result of their debilitating respiratory issues, many EEOICPA patients will also need assistance with the tasks of daily living. The Applicant anticipates in year one, that its patients will be a combination of patients at various stages of disease progression. The Applicant is already providing homemaker/personal care services to 15 patients and anticipates providing these services as a home health agency. Therefore, The Applicant projects 30 patients in the first year with needs as follows: 5 patients needing both homemaker and skilled nursing services; 15 patients needing homemaker services; and 10 patients needing skilled nursing services.

5 (d) The applicant shall provide information concerning whether a proposed agency would provide services different from those services offered by existing agencies.

The response is noted. However, please explain if the actual services the applicant proposes in the service area specific to home health services are different than those home health services already offered by existing EEOICPA home health providers.

Response: The Applicant's proposed services will be different from other home health providers because the Applicant will offer a combination of both homemaker services and "private duty" type home health services specifically to EEOICPA beneficiaries. Many home health agencies in the Service Area are not EEOICPA providers, and many do not provide the type of home health which require longer and more frequent visits that is required of many EEOICPA beneficiaries. Of those home health agencies in the Service Area who are both EEOICPA qualified and provide this type of home health, the Applicant knows of only one that also provides homemaker services and none that provides homemaker services in Morgan County.

3. Section C. Need, Item 1 (Specific Criteria: Home Health Services)- Item 6a and 6b

Please address the following home health criterion:

A) The average cost per visit by service category shall be listed.

Your response is noted. Please complete the following chart:

Provider Type	Billing Code	Charge	Reimbursement
RN	T1001	$153.20	$153.20
HHA or CNA (8 hrs. Shift)	S9122	$24.26	$24.26
LPN (less than 8 hr. care)	S9124	$88.31	$88.31
RN (less than 8 hr. care)	S9123	$107.06	$107.06
HHA per diem (8 hr. shift)	S5126	$140.22	$140.22
LPN per diem (8 hr. shifts)	T1031	$526.36	$526.36
RN per diem (8 hr. Shift)	T1030	$661.33	$661.33
Case Mgmt. (billed in 15 minute increments)	T1017	$17.45	$17.45

B) The average cost per patient based upon the projected number of visits per patient shall be listed.

Please provide the average cost per patient using information from the Projected Data Chart.

Response: Based on the Projected Data Chart, the average cost per patient in Year One would be approximately $71,797.23 and $67,963.57. Since each case is different and EEOICPA reimburses based on hours rather than visits, it is impossible to project the number of visits with any accuracy. Some patients will require 24 hour care and others will require much less but frequent visits. However, if the average number of patient visits is 3 per week than in year one, the projected cost per visit would be $460.25 and in year two, $436.66.

4. Section C. Economic Feasibility Item 4. (Projected Data Chart)

If approved, it is noted in less than 2 years the applicant plans to employ 116 employees at a payroll expense of $3.8 million. Please clarify how the applicant plans to meet payroll while ramping up in Year Two.

Response: The Applicant will hire staff as the number of its patients increases. The Applicant currently employees 19 individuals and has enough in reserve to add an administrator, a director of nursing and will increase staff and payroll as it serves more home health patients and therefore its level of reimbursement increases. EEOICPA pays on a weekly basis and each week the Applicant will be able to add to its reserves in order to grow staff and serve more patients.

SUPPLEMENTAL

Please clarify how Anderson and Morgan Counties has the available pool of qualified home health clinicians for the applicant to employ 116 FTE's in Year Two of the proposed project.

Response: Anderson and Morgan Counties will be serviced by health clinicians from the entire Service Area. Patients will be served by staff that is the most appropriate by skill and logistics which may be residents of another county.

The following completed chart for Other Expenses is noted. However, the chart totals $9,000, not $10,000. Please revise.

Response:

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year One	Year Two
1. Utilities and Telephone	$ 3,000	$ 3,000
2. Insurance	$ 2,000	$ 2,000
3. Professional fees	$2,500	$ 2,500
4. Contingency Fund	$2,500	$ 2,500
5.		
6.		
7.		
Total Other Expenses	**$10,000**	**$10,000**

Please let me know if you have any further questions for the Applicant in order to deem this Application complete.

Very truly yours,

Anne Sumpter Arney

ASA/kh
Enclosures

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Camm Care LLC dba Patriot Homecare

I, Anne Sumpter Arney, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29th day of June, 2015, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires May 3, 2016.

KRISTIE PUTMAN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

HF-0043

Revised 7/02